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AIDS & HIV:

A Manual For Shelter And Residential Program Providers

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Published by the Office of the Secretary of State,
Michael Joseph Connolly, Secretary

904/312

*A Manual For Shelter And Residential
Program Providers*



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ACKNOWLEDGEMENTS

For support in the writing of this manual, we would like to thank:

Project Hope

Pine Street Inn

Boston Health and Hospitals

Health Care for the Homeless Project (Healthlink)

Massachusetts Shelter Providers Association

Massachusetts Department of Public Health

AIDS Action Committee

The Connecticut Coalition Against Domestic Violence

Hale and Dorr

Massachusetts Department of Public Welfare

Bay Cove Mental Health Centre

Our special thanks goes to:

Peg Lorenz

Kathy Williams

Janet Bath

Tom Koroff

Midori Fujii

Elcira Villareal

Donna Scarpa

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INTRODUCTION

Laura came to the shelters four years ago. She sought refuge within the shelters as she was poor and unable to afford housing. It took us all by surprise, most of all Laura, when she began losing weight and developing chronic mouth infections. During a brief hospital stay, she found out she was HIV infected, and it soon developed into AIDS. It is believed that she contracted the virus through unprotected sex with her ex-husband as she was not involved in any of the stereotypical behaviors associated with the transmission of HIV.

Most of us knew Laura when she had been involved in a loving relationship with one man for several years. Laura openly admitted her diagnosis; and during her time at the shelter, she turned to the staff for support and help in dealing with her illness. Yet she abruptly returned to her family before she died without ever revealing to her family that her illness was related to AIDS.

Laura was special to many of us, and she will always be remembered for her vitality and gentleness. Stories like Laura's will be told again and again. Not just in shelters though, for her story is not unique. The problems surrounding AIDS impact all of us. It is inevitable that we as shelter employees will provide services to people with AIDS (referred to as PWAs) and HIV infections. And it is tragic that many of the people we work with are at risk for contracting HIV because of the lack of information about the virus and risky behavioral practices. These behavioral practices can greatly increase a person's risk for acquiring the disease.

It is difficult for shelter providers to cope with such a life-altering crisis as AIDS when our primary focus is the bread and butter of a guest's day-to-day survival. Thereafter, we need to educate ourselves and those with whom we work about this epidemic in order to do our job more effectively and to overcome our own fears.

The reality is that we all must cope with HIV in our private and professional lives. This manual attempts to assist you as shelter providers to deal with the crisis surrounding AIDS and the HIV infection.

As people who work inside shelters, we were looking for some concrete guidance about the AIDS issue. In our search, we found nothing which was designed specifically for shelters; and thus, we began the task of trying to put together this handbook. We tried to use our experiences of shelter life to redefine the body of knowledge concerning AIDS.

In order to identify the questions and issues that concern shelters, we sent out a questionnaire to shelters across the state. It was apparent from the replies we received that there needed to be a handbook which provided basic information about the AIDS virus, its transmission and guidelines for legal, ethical and psychosocial concerns.

As we introduce this handbook, it is important to understand, at the same time, what this manual is not. The manual is not meant to serve as a training guide or the only resource for people whose work includes providing services to people with AIDS or at risk for contracting the virus. We have not tried to supply all the answers about AIDS; rather, we have made some of the tools available to help us deal more knowledgeably with the crisis.

We will cover many different topics, a few of which were already mentioned. We tried to give an introduction to each of these concerns but we emphasize that the body of knowledge is constantly growing and changing as research of AIDS continues. We encourage you to keep learning as new information becomes available. The one thing we remain sure about is that the mode of transmitting AIDS has not changed since it was first identified.

Let us be very clear that homelessness is in no way a risk factor for contracting HIV. However, the reality is that there are not enough services or available affordable housing so shelters are seeing and serving men, women and children who are HIV infected.

In the United States, the number of people who are infected with HIV is approximately between one and one-and-a-half million (1,000,000 - 1,500,000). In Massachusetts, the number is estimated at 30,000. The number of reported PWAs in this state is 2,133, of which 1,008 or 48% have died. (These figures were supplied by the Center for Disease Control, March, 1989). Obviously the trends in the U.S. are also trends that we will see reflected in the shelters.

We need to take control of this epidemic now.

Poor access to services, funding difficulties and increasing numbers of people in need of our help make our job as shelter providers all the more difficult. Now we are asked to extend our services to homeless persons with AIDS. Historically, providers and advocates of the poor have accepted the challenge that society has placed on them. Our new challenge is to assist PWAs in the shelters and to prevent transmission of HIV. The primary goal should be to help people to live with their disease, to prevent transmission and to continue to provide an environment which sacrifices no one's dignity. We must treat everyone in a humane manner and help all homeless people to be as healthy as possible.

It is our responsibility to be informed about AIDS and HIV. We need to educate ourselves and others to minimize the risk of transmission and to help to expel myths and fears.

In summary, this manual is simply a general reference tool. No one should read this cover to cover, and it should not be viewed as an intricate guide on how to counsel PWAs or people who are HIV infected. Due to the vast amount of information, it is difficult to review all the issues that surround AIDS. We could not hope to cover the issues about the disease that are culturally influenced. Each community of people has separate needs, and we were not able to address effectively all of these. Please use your local groups to assist you in specific tasks such as AIDS advocacy and counseling.

The authors of this manual are a group of shelter and health care providers who came together with the sole purpose of compiling a handbook for shelter workers. The following is a list of people and their associated organizations who worked on this manual. It should be noted that the writers and not the organizations are solely responsible for its content.

Tom Bennett	..	Health Care for the Homeless (Healthlinks)
Barry Bock		Pine Street Inn
Tom Clark		Pine Street Inn
Sister Rita Curran		Project Hope
Bob Johansen		Pine Street Inn
Cole Mansfield		Pine Street Inn
Barbara McInnis		Health and Hospitals
Andrea Provan		Pine Street Inn

ETHICAL

AIDS and HIV are scary. No one was able to predict how AIDS would have such a tremendous impact on everyone. HIV does not discriminate. It is not a poor disease or a rich disease or a gay disease. It is not a black disease or a white disease or an Asian disease. It is just there, and we can all be at risk.

The vast majority of us can reduce our risk by changing our behavior; however, there are a small number of individuals (less than 5% of those who are HIV infected) who contracted the virus by being born to an HIV infected parent or through receiving infected blood products. (All donated blood since 1985 has been screened for the virus.)

It is important for us to acknowledge that AIDS and HIV infection and the potential for infection are frightening. Most of us when we entered into whatever job we chose to do, whether it is in a shelter, a health care facility, a laundry, an office or a school, did not anticipate the impact HIV would have on our work and daily lives. However, the reality is that we must recognize that we are all potentially at risk based on our individual behavior patterns. We also need to acknowledge that people who are HIV infected and people living with AIDS must deal with the reality that their life may be shortened due to an AIDS related illness. We as providers of services must not deny individuals their dignity and their rights. In fact, it is our obligation to help people live with their HIV infection as well as to help people protect themselves from becoming infected.

In order for a shelter to set policy with regards to HIV infection and AIDS, it is necessary for the shelter providers to understand as a whole what their belief is concerning AIDS. Each shelter has an obligation to put forth policies regarding people who are HIV infected and in the shelters. This includes guests, staff and volunteers.

All persons have a right to be educated about HIV. Up-to-date information and community resources should be readily available. This information should be presented to the guests, either by the staff or by agencies skilled in this task. (See community resources section for resources in your area.)

One of our goals should be to provide people with the necessary information so that each individual will know how the risk of HIV transmission may be minimized. In this way, each person is empowered to make informed decisions about his or her behavior in light of this virus.

We believe that shelters and all other organizations have an obligation to create policies that attempt to provide a safe environment, i.e., one free from prejudice for staff, guests and volunteers. (See policy section for sample policies.) Our hope is that through education, myths and fears may be dispelled.

People who are HIV infected often have to deal with discrimination. Some of this prejudice is based on hysterical fear of the illness. It also can be a reflection of discrimination based on differences in behavior, class or disability. These prejudices can be further compounded by the stigmas attached to drug use and even homelessness.

It is, therefore, obvious that the problem goes much deeper than fear of the disease itself. Education may help to allay some of the fear surrounding HIV but we believe it is necessary for shelters to create policies that will minimize blatant shows of prejudice and help ensure the individual's rights. We feel that it is unethical to

discriminate against staff, volunteers, board members, residents and their children or other persons because they are known to be HIV infected or because they are perceived to be at risk for HIV. It is unlawful to discriminate based on HIV status or AIDS.

As you may have noted, we do not use the term AIDS Related Complex (ARC) in this manual. We believe people may be discriminated against if they are diagnosed with "only" ARC vs. AIDS. ARC and AIDS are essentially the same syndrome but differ only in symptoms or illness.

We also do not believe in risk groups. People are individuals and should be treated as such. Individuals may practice unsafe sex or share their works which will place them at risk for HIV infection. It is not whether someone is gay or straight or an intravenous drug user that necessarily placed them at risk. It is their behavior that increases their chances of transmission of the virus.

In this manual, we use the phrase "people with AIDS" (PWAs) rather than talking about AIDS victims or AIDS patients. We feel that it is vital that we recognize that the virus infects people and that this should be our focus. We may refer to people as "the alcoholic in bed #18" or "the I.V. drug user in the lobby." This depersonalizes individuals and reduces them to labels. We often lose sight of the fact that alcohol, drugs or HIV affect people. People are more than just a label, and we must always be conscious of the way we speak about individuals. When we speak about the AIDS epidemic, we must always put people before the virus.

It would be a grave error to take safety measures (i.e., gloves when coming in contact with body fluids) only when working with individuals that you know are HIV positive. It is not possible to know who is HIV positive or negative nor is it necessary if you are taking the precautions as outlined in this manual.

We wish to reinforce what is stated in this legal section in regards to HIV and AIDS. You cannot discriminate against an individual based solely on their lifestyle or HIV infection. These rights are protected by Massachusetts General Law. In addition, people have the rights of privacy. This means that you cannot casually disclose information about a person's HIV status or AIDS to counselors or their agencies. There may be a rare circumstance (i.e., social security benefits) where it would be in the guest's best interest to share information in regards to an AIDS diagnosis. However, the guests should always be consulted prior to sharing this information. Since the law is not black and white in regards to AIDS within the shelters, we urge each of you to set forth policies that clarify your shelter's position. (Please see PSI policy in policy section.)

Another very real concern is if a person has AIDS or is HIV positive and also happens to be homeless, will they be denied access to some forms of health care? Every day new treatments with experimental drugs and holistic care are being developed to prolong and improve the quality of life for a person with AIDS and HIV infection. However, access to these treatments is limited, and they have strict criteria for participation. There is potential for homeless persons to be denied access to this care simply due to their social situation.

We believe that to be denied access to care is intolerable. We feel that all advocates should feel outraged about the potential denial of services due to homelessness. Thus, we believe that our responsibility as advocates goes beyond the walls of our individual shelters. We must work with state and local agencies as well as the legislature to ensure that all individuals have equal access to care.

LEGAL

There are many legal issues concerning shelter guests or staff who have AIDS or HIV illnesses. At times the law is very clear about what should or should not be done. However, there are several areas where the law is not clear-cut. From a legal perspective, AIDS should be considered a physical handicap protected under federal and state laws. These laws define a handicapped person as "any person who 1) has a physical or mental impairment which substantially limits one or more of such person's major life activities; 2) has a record of such impairment; or 3) is regarded as having such impairment."

The legal precedent protecting handicapped people with infectious diseases was set in a 1987 Supreme Court decision (*School Board of Nausau County v. Arline*). Following this decision, the federal government applied protections against discrimination to all HIV infected individuals. This decision has also been followed in interpretations of the Massachusetts Commission Against Discrimination (MCAD) and state courts. These determinations state unequivocally that people with AIDS or ARC or suspected of having AIDS are protected under Massachusetts General Laws c. 151B which prohibits discrimination on the basis of disability.

The focus of the following guidelines is on Massachusetts law which may differ significantly from the laws and statutes of other states. In all legal aspects of dealing with people with AIDS, however, it should be pointed out that laws, when applicable, establish minimum standards only. Each shelter or agency must confront the ethical as well as the legal questions and should articulate a policy that reflects its own philosophy or mission statement. Each shelter should decide how they as an agency or organization will deal with guests and staff who have AIDS or who are perceived to be at risk for AIDS.

We have grouped our discussion of legal issues into four areas: 1) the liability of agencies for failure to provide services to people with AIDS; 2) liability in employment of people with AIDS; 3) confidentiality issues relating to guests with AIDS; and 4) liability for negligence in preventing transmission of HIV.

LIABILITY OF AGENCIES FOR FAILURE TO PROVIDE SERVICES:

Under federal and Massachusetts law, it is illegal to discriminate against people with AIDS in either public housing or admission to public accommodation, including shelters. This means that *shelters are required to provide service to people with AIDS or perceived as having AIDS and may be liable under the law if they fail to do so.*

This does not prevent shelters from setting reasonable standards of behavior, however. For example, if it is a shelter's policy to bar or apply other sanction to guests who are found to be using IV drugs on the premises, then these same sanctions could be applied to someone who has AIDS. Or, if a person with AIDS commits a violent act, he or she should be treated in the same manner as others who commit violent acts. *What is illegal is to bar someone solely on the basis of their AIDS diagnosis or the perception that they might have AIDS.*

Also, shelters may set guidelines for the level of illness that they are able to manage. However, they need to make a reasonable accommodation for people with AIDS, just as they are mandated to make reasonable accommodations for people with other physical and mental handicaps.

LIABILITY IN EMPLOYMENT:

The Massachusetts Commission Against Discrimination in its 1986 AIDS policy specifically applies the protection of the Massachusetts Fair Employment Act (M. G. L. c. 151B) to people with AIDS or perceived as having AIDS. The guidelines issued by MCAD hold employers liable for handicap discrimination, for refusal to hire or advance individuals with AIDS or those perceived as having AIDS, or for inquiring as to whether an applicant has AIDS or is at risk for contracting AIDS if that person could perform the job with "reasonable accommodation." *Under these guidelines, the employer's fear of contracting AIDS or the fears of customers or other employees of contracting the illness are not sufficient cause for discrimination.*

If an employee becomes sick and chooses to continue working, "reasonable accommodation" must be made to allow that individual to continue, as long as they are able to meet acceptable performance standards and do not pose a substantial medical risk to either themselves or others.

Also, as there is no evidence that AIDS can be transmitted through casual contact, employers who disclose an employee's AIDS diagnosis to other employees are liable for prosecution under the Massachusetts Privacy Statute (M. G. L. c. 214) which states that a "person shall have a right against unreasonable, substantial or serious interference with his privacy."

CONFIDENTIALITY ISSUES RELATING TO GUESTS WITH AIDS:

One of the most sensitive legal issues relating to AIDS and HIV is the question of confidentiality. Who has the right to know that a particular guest at a shelter has AIDS or tests HIV positive? The laws around this issue are neither specific to shelters nor to AIDS in particular. There is a law (M. G. L. c. 111, s. 70F) which prohibits health care facilities and providers from disclosing someone's HIV status without first obtaining written consent. And the Massachusetts Privacy Statute states that every person has a "right against unreasonable, substantial or serious interference with his privacy."

Each shelter should have in place universal infection control precautions which protect both staff and other guests. When this is the case, staff, volunteers or other guests have no need to know who has AIDS and who tests HIV positive. It should be the guest's decision who should know about an AIDS diagnosis (or any other personal health information). Staff should get the guest's permission to tell other staff or ask the guest to inform other staff directly if it seems indicated. Without the permission of the guest, preferably in writing, the agency is potentially liable for violating the Privacy Statute and would need to prove that this was required to protect the client from imminent harm or to protect a person who is unknowingly in danger of transmission. Because of the sensitivity of this issue, shelters should have clear guidelines established for when and how such decisions to violate

confidentiality should be made and the form that the release would take. Universal precautions established by the shelter and consistently enforced protect staff, volunteers and other guests from infection. There is no need to single out for special treatment people with AIDS or who are believed to have AIDS, or to violate their legal right to confidentiality.

LIABILITY FOR NEGLIGENCE IN PREVENTING TRANSMISSION OF AIDS:

There is potential liability to shelters and agencies for failure to protect staff and guests from infection by HIV. An employer might be found negligent if it could be proved that an employee contracted AIDS while performing his or her job and no infection control guidelines were in place to protect that employee. *To repeat what has been stated previously, there is no medical evidence that AIDS is transmitted by casual contact or the normal activities of the shelter. However, it is the shelter's obligation to educate its staff and to institute universal precautions to protect the safety of staff and guests.*

SUMMARY:

The laws affecting people with AIDS will continue to change over time. Shelters have an obligation to make sure that their information is current and that the policies and procedures they follow in providing services to the homeless reflect the legal protections guaranteed to guests and staff.

The shelter community embodies considerable diversity in philosophy and approaches to providing services to the homeless. It is important that the staff board of directors, volunteers and guests of each shelter be involved in a discussion to articulate how they will meet the needs of people with AIDS in a way that is consistent with their own understanding of their shelter philosophy.

PSYCHOSOCIAL

INTRODUCTION TO THE PSYCHOSOCIAL NEEDS OF THE PERSON WITH HIV/AIDS:

It is okay to be scared; it is what you do with fear that counts.

AIDS generates a unique series of stresses for persons with the disease as well as stresses for their lovers, spouses, family members and health care professionals. It creates problems for everyone with whom the person has close contact. Although much of the formal counseling about HIV / AIDS is done at a clinic or hospital, a person who finds out he or she has HIV or AIDS goes into a state of crisis or emotional shock. When a person hears this news, he/she begins to feel the sudden impact of the illness when discussing it with family or friends. If a guest's family or friends is not available, for whatever reason, the shelter worker often falls into the role of and becomes an extended family member or friend.

With all persons with AIDS, a shelter must be particularly careful with how it chooses to handle prejudice. Prejudice is more easily recognized in other people (i.e., "But not people like me."). Still we can learn about its causes and help to eliminate any prejudice by our openness to education and commitment to the homeless. Prejudice distorts judgment with negativism and insensitivity. Prejudice causes PWAs to be seen as aggressors who got what they deserve. When people are designated as targets of prejudice or being "different", and therefore, less deserving of basic human rights, they become mistreated by our society. We can lessen the stigma attached to HIV / AIDS by our increased understanding and acceptance.

The guest with a positive HIV test or AIDS is in a vulnerable and compromised position, the same as anyone with a diagnosis of a life-altering illness. In addition to the physical problems that affect a person with HIV / AIDS, there are psychosocial problems as well.

We are part of a society that has been disrupted by the deluge of new information about sexual behavior and drug use. Historically, conversation about these subjects has been hidden in back rooms. When the information uncovered about HIV / AIDS is integrated into our general store of knowledge, we will have a better understanding of sexuality and substance abuse.

Whole sexual lifestyles have changed already in the United States and abroad and will change much more drastically when it becomes widely known that the disease can be transmitted through any, even regular, sexual intercourse since no one really ever knows another person's sexual or drug history.

By allowing yourself to learn the facts about HIV / AIDS, your fears will be lessened and you will be a sensitive and supportive counselor or advocate. The information in this section is shared with the hope that no guest or client should have to live with the added burden of confronting the fears and prejudices of shelter workers.

Since homeless people are already in a state of crisis, some of these behavior changes may be subtle and difficult to recognize. Familiarity with a person and

his/her behavior is the most important part of a relationship between a shelter worker and a guest.

Homeless people with HIV / AIDS face the same problems as non-homeless people with the disease. Both suffer from a fear of death and dying, a sense of vulnerability, the threat of disfigurements, the loss of independent functioning, the need to prepare for one's death, prejudice and more. By allowing yourself to learn about HIV / AIDS, you will be more able to allay the fears and anxieties of PWAs.

ALIVE WITH AIDS

One of the best kept secrets of AIDS is survivors. A survivor is a person who keeps bouncing back, stronger after each illness, much like cancer patients who outlive the doctor's predictions. In an article written by an AIDS survivor who travelled cross country to interview other AIDS survivors, he often asked, "To what do you attribute your longevity?" Some survivors said, "Diet Coke or Classic Coke." Some said, "Massage or acupuncture." But all said "HOPE" helped them to live longer. They were asked questions like, "Am I happy?", "How do I feel about my life?" And they said they only kept up those relationships that were not stressful. Another fact which came from the article was all the long-term survivors knew other long-term survivors. Knowledge about the disease and ways to improve the quality of life was very important to them. Without a doubt, maintaining hope is the most important precondition for survival.

PSYCHOSOCIAL REACTIONS OF PERSONS WITH ACQUIRED IMMUNODEFICIENCY DISEASE:

The psychological effects on people who have been diagnosed with any life-altering disease is usually met with such severe stress that the news can best be described as catastrophic. Catastrophe often produces situational distress. Situational distress often occurs in three phases: crisis, transitional and deficiency status. The reaction of people with AIDS follows the same pattern with the frequent addition of a fourth state: the preparation for death.

INITIAL CRISIS

The effects of life-altering illness in guests are met with an acute response of denial, alternating with periods of intense anxiety. The denial can be so complete that the person will adopt an attitude of indifference which may lead to a dangerous disregard for medical advice. Persons may be overwhelmed by emotion or increase their denial, even to the point of engaging in life-altering behaviors if the denial is allowed to become more prominent. This is the time to be aware of the usual emotional reactions to AIDS which include shock, denial, guilt, fear, anger, sadness, bargaining and finally acceptance.

One of the most disruptive complications of AIDS is its impact on otherwise supportive relationships. Is his/her homosexuality known and/or accepted by those people meaningful to the PWA? Will the onset of AIDS force the disclosure of previously disguised drug use in the drug addicted person? This is the time to initiate contact with existing support services; because during this crisis state, the

PWA typically has difficulty retaining information and may distort what they are told regarding their illness. Concrete support such as crisis counseling, legal and financial assistance, death and burial should begin as early as possible as it may help to clear up some of the emotional numbness that can set in.

TRANSITIONAL STATE

The transitional state usually begins when alternating waves of anger, guilt, self-pity and anxiety start to supersede denial. Persons may become obsessed with reviewing their past in an attempt to understand what they may have done to "deserve" AIDS.

The transitional period is a time of distress, confusion and disruptiveness. Social rejections are deeply felt, aggravating the situation. Changes in self-esteem, identity and values, estrangement from loved ones, caretakers and community, and even consideration of suicide may occur. However, despite the dangers present, or possibly because of them, PWAs are seemingly more accessible to psychosocial intervention at this time.

Severe social withdrawal may also occur, it is a dangerous reaction in which persons refuse to deal with the disease and avoid friends, family and caretakers. Some guests may displace his/her anger by continuing sexual and drug-related behaviors which endanger themselves as well as others. This behavior is usually a sign of anger and not a deliberate attempt to spread HIV / AIDS. Fear or depression may also be apparent in the individual. Suicide may be mentioned and must be considered a psychiatric emergency.

Additional stress in the transitional stage results from feelings of loss and impending doom. Tremendous anger may not be expressed because of the bargaining reaction in which PWAs hope to be cured by promising to be "good". Consequently, fear and depression, rather than anger, are more likely to be exhibited by such guests.

DEFICIENCY STATE -- ACCEPTANCE

Formation of a new stable identity occurs upon reaching the stage of acceptance. PWAs learn to accept the limitations that AIDS imposes on them but also realize they can still manage their lives by reacting to the disease with more reason than emotion. In making a conscious effort to live each day fully, these PWAs examine sources of pain and pleasure, reassess the value of courage, commitment, affection and concern for others and learn to appreciate quality of life rather than quantity.

Reaching the state of acceptance can be eased by contact with other PWAs who can serve as role models. Support group involvement gives PWAs opportunities to learn new social skills such as experiencing non-sexual intimacy and/or non-drug using behavior. The acceptance state still must be viewed as a deficiency state, however, as is evidenced by losses of health, energy and independence.

Identity crises produced by AIDS include: fear of death and dying, sense of vulnerability to opportunistic infections, the threat of disfigurements, the continued

loss of independent function, prejudice from others, the loss of friends and acquaintances who die of AIDS and, finally, the need to prepare for one's death. These are crises that need or require permanent adjustments.

PREPARATION FOR DEATH

In the early stages of the disease, PWAs may benefit from completing unfinished business such as asking for or granting forgiveness, seeing or speaking to certain persons again or completing an unfinished project. When PWAs are comfortable talking about death, they should be encouraged to share feelings about how and where they would prefer to die, i.e., funeral arrangements. The desires of PWAs living in shelters may be difficult to honor. On the other hand, hospitals may require more medical intervention than PWAs want. And their families may have often long since alienated them. For these reasons, it is imperative that we help the PWAs to connect with the various community support groups early in the diagnosis.

GUIDELINES FOR MEETING THE PSYCHOSOCIAL NEEDS OF SHELTER WORKERS WHO COUNSEL GUESTS/CLIENTS AT RISK FOR OR HAVING HIV INFECTION:

1. Orientation to working at an agency that provides services for homeless people can include information about HIV, AIDS, IV drug use, substance abuse and sexual orientation.
2. Each worker has his/her own personal fears about HIV / AIDS. When fears are voiced and explored in a supportive setting, facts can be separated from myths. By becoming aware of our fears, feelings and responses, we can ready ourselves to be a better listener, counselor and advocate.
3. Once you give a guest the okay to discuss personal matters (either by verbal or non-verbal communication), you can allow for an open discussion by listening without judgment. After the shock of the diagnosis and its implications has been shared with you, a guest/client has a better chance to come to terms with the facts emotionally. How this happens may be unclear or distorted when the guest/client has symptoms of mental illness or substance abuse.
4. Confidentiality must be maintained at all times when talking to other people unless permission to discuss this matter has been verbalized by the guest/client.
5. In person-to-person contact with a guest/client, we can maintain casual contact (talking, touching, etc.) as existed before the news of HIV infection.
6. When a guest/client is ready, you can explore ways for him/her to maintain control of his/her life and make referrals as needed for health care, counseling, legal advice or spiritual guidance.

7. Some outstanding characteristics about HIV / AIDS are:

- A. *When relatively healthy people have a positive HIV antibody test, it indicates the presence of the HIV virus and does not in itself mean the person has AIDS. Like having a positive test for cancer, there can be a long period of time before symptoms appear.*
- B. *A person may have a series of infections and once the diagnosis of AIDS is made, there is a range of time before they become terminally ill and die.*
- C. *Few diseases are as frightening to people as AIDS. In addition to the fear of death, people with AIDS often face rejection by friends and society.*
- D. *It is difficult to watch young people die of AIDS.*
- E. *There can be over identification with a guest/client because of similar age, lifestyles and interests or habits. Your sense of vulnerability and fragility may also be threatened and make you feel anxious.*
- F. *If support for these feelings is not available to you from supervisors and co-workers, find out where in your community support is available. Many of these resources are listed elsewhere in this manual.*

8. As shelter workers, we are caring for homeless people in a setting where men and women are welcomed as friends. It is in an expectation that dignity is valued and respected. When this happens, hope is fostered.

MEDICAL

INTRODUCTION TO THE MEDICAL SECTION:

In this section, we begin a basic description of the spectrum of HIV infection and the AIDS virus and its origin. We also offer current national statistics and a summary of the criteria for the diagnosis of AIDS used by the national Centers for Disease Control (CDC). Subsequent sections will address the topics of serologic (blood) testing for HIV infection, the ways in which the virus is transmitted, common HIV related illnesses and a table of the medications most often used. This is meant to serve as an introduction to the medical aspects of HIV infection, evaluation and treatment. As the number of published articles devoted to AIDS/HIV now approaches 10,000 per year, a comprehensive discussion of the syndrome would be impossible. The reader is encouraged to consult with a familiar medical provider for additional information.

Part of what makes the acquired immune deficiency syndrome particularly frightening is the uncertainty of its origin, transmission, various disease manifestations, treatments and prognosis, especially the earliest stages of HIV infection. The first reports of unusual infections and malignancies (cancers) affecting certain "risk groups" appeared in the U.S. in 1981. Yet, there is strong evidence that people died of AIDS related diseases as early as the mid-1970s. Human blood samples from several other countries have also revealed the presence of HIV infection as early as 1958. Several theories for the origin of the virus have been presented as a result of these findings.

It is believed that transmission of the virus occurred originally through heterosexual contact. This is felt to be the reason for the increased incidence seen in a number of countries outside of the U.S. This history becomes an important point for those who view AIDS strictly as a disease of gay men and IV drug users.

The investigation of AIDS transmission took on a greater urgency when, in 1982, the first cases were reported in hemophiliacs and other recipients of donated blood products. This discovery now represented a threat to the nation's blood supply. Whatever the reasons for the initially sluggish recognition of this emerging public health crisis, finally in July 1982, the term "epidemic" was applied to this outbreak of immune deficiency, after 471 cases had been reported to the CDC, 184 of which had died. By mid-1982, the acronym AIDS was generally accepted. The word "acquired" distinguishes this type of immune deficiency from other forms which may be present at birth or as a result of medications or chemicals.

Early in 1984, independent laboratories in France and the U.S. isolated the virus now confirmed as the cause of AIDS. Researchers originally termed it the Human T-cell Lymphotropic Virus, Type III (HTLV-III) in the U.S. and the Lymphadenopathy-Associated Virus (LAV) in France. The accepted term is now the Human Immunodeficiency Virus, Type I (HIV-1). This is often referred to as simply HIV, although it should be noted that at least one other HIV of major interest (HIV-2) has been identified in western Africa and other countries that have substantial maritime connections.

As of November 30, 1989, there were 112,000 cases of AIDS in the U.S. reported to the CDC of which more than 50% are known to be dead. In 1989 alone, 33,000

cases were reported. Males account for 91% of all cases, 9% are female and pediatric cases account for 1.6% or approximately 1,400 cases. The transmission categories for AIDS as recorded by the CDC are as follows (as of December 26, 1988):

<i>Homosexual/bisexual male</i>	62%
<i>Intravenous drug user</i>	20%
<i>Homosexual male and IV drug user</i>	7%
<i>Hemophilia/coagulation disorder</i>	1%
<i>Heterosexual transmission</i>	4%
<i>Transfusion/blood components</i>	3%
<i>Undetermined</i>	3%

In Massachusetts, which ranks ninth among states for total AIDS diagnoses, the cumulative number of cases is 2,700 (2.4% of the national total). Of the total cases, 48% are known to be dead. In terms of medical expense, some researchers estimate the cost of caring for a person with AIDS is \$50,000 per year.

The spectrum of HIV infection is broad. The infection ranges from seropositivity only, (HIV antibodies in the person's blood without signs or symptoms of illness) to the patient with advanced immunosuppression. Someone with advanced immunosuppression may be marked by severe wasting (weight loss), physical or mental deterioration and having one or more opportunistic infections. There are multiple uncertainties of paramount importance to the patient who has learned of a "positive test" result, such as who will remain healthy and for how long, who may expect disease progression, life expectancy and other predictors of good or ill health (so called prognostic factors). These questions are seldom able to be answered with certainty.

A detailed description of how HIV impairs the body's immune system is beyond the scope of this manual; however, a brief summary of the infection is important.

Upon entering the body through any of the mechanisms outlined in the section entitled "route of transmission", the virus preferentially infects certain cells of the immune system, namely, T-lymphocytes. The virus can then "instruct" the host cell to help reproduce the virus through a complex series of reactions that are specific to this class of viruses called retroviruses. Unique to these viruses is an enzyme called reverse transcriptase. This is used to reproduce the virus' genetic material. A number of the medications which are still under investigation act at various steps in the process of viral infection and replication. These T-lymphocytes, specifically the T-helper cells or T-4 cells, are ultimately destroyed by the virus, resulting in the decreased "T-cell counts" seen in many people with advancing illness. In addition to these lymphocytes, HIV also has a tendency to seek out certain other cells, e.g., those lining the colon and rectum and certain cells of the brain, spinal cord and other parts of the nervous system. Other factors which may contribute to the

progression of the disease include a number of "co-factors" which impair a person's immune system, for example, repeated exposure to the virus, recreational drug use, concurrent illness or infection, excessive alcohol intake, pregnancy, anxiety, trauma and poor general health. The initial HIV infection, in perhaps one-fourth of individuals, may appear as a flu-like illness lasting perhaps a few days to two weeks. Symptoms include fever, fatigue, headache, sore throat, muscle aches, rash and swollen glands. These are non-specific symptoms that are typical of a variety of more common illnesses; therefore, a guest presenting with these symptoms should not be assumed to be HIV infected. When HIV is the cause, however, development of serum antibodies to HIV (seroconversion) generally occurs at this time. Guests then usually enter an asymptomatic period lasting six months to one year; in many individuals, this period extends to many years. Predicting who will experience disease progression cannot reliably be done at this point. However, estimates on the proportion of HIV infected individuals who will become ill suggest that 5-10% of asymptomatic seropositive individuals will develop symptoms each year and that one-fourth to one-third will develop AIDS within a five year period. It must be remembered that as therapies change and new anti-viral medications are approved for use, we expect these survival rates to increase dramatically.

The term ARC (AIDS related complex) was used to describe those individuals who, although not meeting all the criteria for a diagnosis of full-blown AIDS, showed signs and/or symptoms of fever, weight loss, enlarged lymph nodes, fatigue, night sweats and diarrhea, lasting more than several weeks. Guests may also have exhibited oral "thrush" (candidiasis or yeast infection of the mouth), and this generally resulted in a worse prognosis. Although the terms ARC and "pre-AIDS" are still often used, there is such variability in the way the terms are used, that they are being replaced by more specific descriptions, and usually in the setting of a known HIV antibody status. For instance, PGL (persistent generalized lymphadenopathy) refers to enlarged lymph nodes in at least two sites other than the groin (e.g., neck or armpits) which persist for at least three months. In 1986, the CDC set forth specific diagnostic criteria for AIDS (full-blown AIDS, fully-developed AIDS). A summary of these criteria follows. Note that specific disease states are defined elsewhere in subsequent sections and the glossary.

Diagnostic criteria for the acquired immunodeficiency syndrome: Person a) with risk factor for HIV infection or without risk factor for HIV infection but with positive HIV serology or culture; and b) with no other identifiable underlying immunosuppressive illness who has one or more of the following manifestations:

1. Pneumocystic carinii pneumonia.
2. Other serious opportunistic infections including:
 - A. *Pneumonia, meningitis, encephalitis due to one of a group of fungal, bacterial and viral agents which cause infections only in an immunocompromised state; examples are toxoplasmosis, cryptococcus and atypical mycobacteriosis;*
 - B. *Esophagitis due to candidiasis, cytomegalovirus or herpes simplex virus;*
 - C. *Progressive multifocal encephalopathy (a viral infection of the brain);*
 - D. *Chronic (greater than one month) enterocolitis (intestinal infection) due to cryptosporidiosis or isosporosis;*
 - E. *Chronic (greater than five months) herpes simplex infection of the mouth, skin or anus;*
 - F. *Disseminated histoplasmosis (a fungal disease).*
3. Kaposi's sarcoma.
4. Other malignant neoplasms predictive of cellular immunodeficiency:
 - A. *Non-Hodgkin's lymphoma of a high-grade pathologic type;*
 - B. *Primary central nervous system lymphoma.*
5. Chronic lymphoid interstitial pneumonitis (an inflammatory disease of the lungs which qualifies as AIDS when present in children under 13 years of age).

In 1986, the CDC also proposed a classification system which encompasses the entire spectrum of HIV infection. Standardizing the way in which persons with HIV infection are classified serves several purposes. These classifications improve disease reporting and surveillance, research, disease prevention and public health policy and planning. The classification scheme developed by the CDC is below:

CLASSIFICATION FOR HIV INFECTION:

Group I	<i>Acute infection</i>
Group II	<i>Asymptomatic infection</i>
Group III	<i>Persistent generalized lymphadenopathy</i>
Group IV	<i>Other diseases</i>
Subgroup A	<i>Constitutional disease</i>
Subgroup B	<i>Neurologic disease</i>
Subgroup C	<i>Secondary infectious diseases</i>
Subgroup D	<i>Secondary cancers</i>
Subgroup E	<i>Other conditions</i>

The above classification systems illustrate how HIV infection presents as a wide range of illnesses and not as a single disease. Not all clinicians or hospitals use the above systems to classify or diagnose their patients with HIV infection. The ability to predict disease progression (prognosis) is of greatest importance to the HIV infected individual but at this point can be done with little certainty. Therefore, the guest must be encouraged to optimize his health status through positive changes in lifestyle, nutrition, reducing as much as possible the use of alcohol and other drugs and maintaining regular visits with a health care provider. In addition, the guest must be counselled as to the ways in which he/she can reduce the likelihood of spreading HIV to other individuals.

ROUTES OF TRANSMISSION:

In order to understand how HIV is transmitted, we must first understand which of the body fluids are capable of harboring transmissible virus. A number of factors come into play: the composition of the particular fluid, the quantity as well as the viability of the virus, and so on. It is common knowledge that the virus can be transmitted through semen or vaginal secretions in unprotected sexual intercourse or by the injection of infected body fluids. The virus has also been found in small amounts in other body fluids. Whether these other fluids are capable of infecting individuals is an important question not only for researchers but also for guests and staff of shelters where non-intimate contact with many individuals occurs on a daily basis. In general, transmission from these other fluids has not reliably been shown.

In this section, we identify those fluids which have demonstrated an ability to transmit the HIV (blood and sexual fluids) and to distinguish these fluids from another group where the virus has been isolated but never proven as an infectious source, (saliva, tears, urine), and those where it does not exist at all (e.g., sweat). The recommendations for handling all body fluids remain unchanged; the intent is to clarify which types of physical contact will and will not increase the risk of HIV transmission.

HIV is a fragile virus and is incapable of reproducing or surviving for long once outside the human body. It is easily killed by disinfectants, bleach, alcohol, even washing with hot, soapy water. As far as sexual contact is concerned, *latex condoms are highly effective at preventing the transmission of HIV (and many other sexually transmitted diseases), especially when used with a water-based lubricant and a spermicide containing nonoxynol 9, which is also capable of killing HIV. Natural membrane condoms, while effective for contraception, are less effective as a barrier to HIV and other viruses, such as the hepatitis B virus.*

The following body fluids are proven to be capable of transmitting the human immunodeficiency virus:

blood semen vaginal secretions breast milk.

Other body fluids have been demonstrated to harbor small amounts of the virus but their ability to transmit HIV is very much in question. This may be due to the fact that these fluids contain relatively few T-4 cells (the lymphocytes preferentially infected by HIV). Whatever the mechanism, this second group of fluids presents a theoretical risk, and at this time, is not considered a significant contributing factor to the spread of HIV infection. *The only significance of these fluids, as vehicles of transmission, would be if they were contaminated with blood.*

This group includes:

sputum and saliva urine bile and vomitus tears.

Studies which have examined the risk of HIV transmission to family members living closely with and caring for people with AIDS have found no cases of HIV transmission, provided the contact was non-sexual and did not involve needle sharing or blood contamination. These findings were consistent despite frequent close physical contact, sharing of household items, kitchen utensils and toilets for an average time of nearly two years. Health care workers who have had significant blood-to-blood or mucous membrane exposure to HIV infected blood have also been studied. Infection with HIV has occurred in rare instances and emphasizes the need for strict adherence to infection control guidelines (e.g., use of barrier precautions). As for other types of casual contact, *there is no evidence to support that HIV can be transmitted through the following mechanisms:*

food preparation

handshakes

shared toilet seats

swimming in pools

working together/attending school together

shared water fountains

mosquito bites

visiting hospitalized persons

hugging/casual kissing

sharing towels, dishes

donating blood (i.e., an individual cannot become

infected by giving blood or plasma)

through pets or animals.

RISK BEHAVIOR VERSUS RISK GROUP:

The concept of defining certain "groups" at particular risk for HIV infection began with the earliest descriptions of the acquired immune deficiency syndrome. However, as we move onto a better understanding of exactly what places an individual at risk for HIV infection, an important distinction deserves to be made. The risk of HIV infection comes from certain behaviors which increase the likelihood of exposure to the virus. The risk of infection does not present itself merely by being part of a particular group. An IV drug user who has never shared a needle and who has never engaged in risky sexual practices or had a sexual partner who is at risk has no greater risk of HIV infection than the general population. Likewise, a gay man's sexual practices will determine his level of risk, not the fact that he is gay. Prior to the routine use of HIV antibody screening, i.e., March 1985,

transfusion recipients comprised a "risk group". Since then, the risk from the transfusion of a single unit of blood has dramatically decreased and is now estimated as approximately 1 in 100,000.

In this section, we list various practices that place persons at risk for HIV infection / transmission. (Please consult the glossary for definitions.)

DANGEROUS:

- 1) *Sharing needles*
- 2) *Unprotected anal intercourse*
- 3) *Unprotected vaginal intercourse*
- 4) *Fisting*
- 5) *Rimming*
- 6) *Internal water sports*

RISKY:

- 1) *Oral sex without a condom*
- 2) *Masturbation on open/broken skin*
- 3) *Deep kissing*

OTHER INDIVIDUALS WHO MAY BE AT RISK FOR HIV INFECTION:

- Recipients of blood/blood products prior to July 1985*
- Infants born to infected or mothers*

ADDITIONAL POINTS:

1. As the incidence of heterosexual transmission has risen in the U.S., the increased numbers of Haitian immigrants with HIV infection was recognized as probably due to a higher frequency of heterosexual transmissions already present in that country. The proportion of total U.S. AIDS cases found in Haitian immigrants between 1984-1986 decreased from 4.5% to 1.5%.

2. It may seem surprising that not all infants born to HIV infected mothers are also infected. In fact, the risk to the fetus is estimated at 30-50%. The reason that transmission does not always occur is that throughout pregnancy, the fetus and the mother's blood supplies remain separate; the placental barrier allows the passage of only certain proteins and nutrients. One of these proteins is the maternal antibody to HIV, and this may persist in the infant's blood for several months following birth, even in the absence of fetal HIV infection. For this reason, HIV antibody testing of the newborn is delayed for several months to minimize the chance of a falsely positive test for the infant. When transmission to the infant occurs, it may happen in utero, at the time of delivery or subsequently while the infant is breast fed, although transmission at the time of delivery appears to be the most common mechanism.
3. Certain recreational drugs act to increase the risk of HIV transmission. This may occur by impairing one's judgment which can increase the chance of participating in risky practices. In addition, certain "vasoactive" drugs (drugs which may affect the blood vessel and blood pressure) such as amyl nitrate, may enhance the blood flow to certain areas such as the rectal mucosa, and thereby increase the likelihood of HIV entering the bloodstream of the previously uninfected individual.

HIV ANTIBODY TESTING:

Quite commonly, guests of a shelter or patients of the various shelter clinics will express a desire to "take the AIDS test". It is, therefore, helpful and important for shelter providers to know what tests are available for detecting evidence of the HIV infection and how a client might obtain such a test. The shelter staff may later be called upon to help a guest to understand and accept these results as well as to connect the guest with other services once those results become known.

Since March of 1985, an HIV antibody test has been available nationwide. Antibodies are highly specific proteins made by the body's immune system as a defense against foreign invaders, such as HIV. Therefore, a "positive test", i.e., one showing the presence of antibodies directed specifically to HIV, means that the individual has been infected with HIV at some point in the past. This may have occurred as recently as two weeks before or many years prior to the testing. Persons exposed to HIV usually develop serum antibody within six to twelve weeks, but antibody production may be delayed for several months and sometimes for more than a year.

The test by itself cannot show whether an individual has AIDS, asymptomatic HIV infection or whether that individual will develop an illness related to HIV. A positive test indicates the body has recognized invasion by the HIV and has mounted an antibody response. Estimates vary on the proportion of individuals who test positively for the antibody and those who will ultimately develop AIDS. These estimates have been previously discussed. A positive antibody test also does indicate that the individual may be currently able to infect other individuals. Therefore, it is generally accepted that anyone with a positive test result should assume that they have a lifetime infection and that they are able to transmit the virus through any of the means noted in the previous section.

The tests which are used most commonly fall into two groups:

1. ELISA (enzyme-linked immunoabsorbant assay), also abbreviated EIA (enzyme immunoassay).

These were the first tests developed and are available from several different manufacturers. The first generation tests were associated with a number of false positives (i.e., a positive test result in a person not really HIV infected), especially when the tests were administered to individuals who are not at risk for HIV. The more recently developed ELISA tests, when performed on appropriate individuals and optimal laboratory conditions, have a 1% or smaller chance of being falsely positive or falsely negative.

2. Confirmatory tests.

Western blot (WB)

Indirect immunofluorescent antibody (IFA)

In Massachusetts, a positive screening test must by law be confirmed by one of these more specific and expensive tests before the results can be reported. In combination with an initial positive EIA, and when reserved for individuals for whom there is some identifiable risk for HIV exposure, the predictive accuracy of a positive ELISA and Western blot exceeds 98%. It is less clear when a person tests positive on the ELISA but negative on the Western blot. In this case, a person's history, i.e., risk behaviors, becomes increasingly important in predicting the likelihood of HIV infection.

Certainly, a number of factors enter into the decision making process between the client and clinician, not only in serologic testing, but also in interpreting test results. The need for pre- and post-test counseling has been recognized since the tests first became available and, fortunately, are required by Massachusetts state law.

A third category of tests, used less widely than the previous two, involve detection of proteins, called "antigens", which are contained on the human immunodeficiency virus itself. Examples are the p24 and gp41 antigens. Such assays are used to answer specific questions during a person's clinical course and are often being tested themselves for their usefulness and reliability.

RECOMMENDATIONS FOR HIV ANTIBODY TESTING

A great deal of controversy surrounds this issue and recommendations for testing may vary widely from different sources. In general, guests who believe themselves to be at risk, whether through engaging in risky behaviors (see section 3) or having sexual partners at risk, are appropriate for testing. In Massachusetts, HIV antibody testing is routinely performed for organ and blood donors, military recruits and life insurance applicants. It is often recommended for "at risk" persons prior to elective surgery or upon hospital admission. The Center for Disease Control has set forth recommendations as to whom should be tested. However, it should be emphasized that the decision to test is a decision made by the guest who is informed and only after appropriate counseling, preferably by a trained counselor and the health care provider. According to the CDC, testing is recommended for:

persons with sexually transmitted diseases

intravenous drug users

*persons who consider themselves at risk or have sexual
partners at risk*

women of childbearing age at risk through IV drugs,

prostitution or sexual contact with other persons at risk

persons born in high risk countries

persons who received a blood transfusion between 1978-1985

prisoners

prostitutes

Any individual who desires to be tested has several options. Anonymous (without using names) testing is available through the various Massachusetts alternative test sites and is free of charge. Testing is also available in most hospital clinics and through the Red Cross, but these testing clinics do not offer anonymity, only confidentiality, so that the results cannot be released without written consent by the person being tested. The results, however, become part of a person's medical record. A list of the available test sites is included in the resources section. It should be emphasized the decision to test for the HIV antibody is an individual decision. Furthermore, it is illegal in Massachusetts to obtain an HIV test without a person's informed, written consent and adequate counseling.

OPPORTUNISTIC INFECTIONS:

Opportunistic infections which are caused by bacterial, fungal and parasitic agents found throughout the environment would not cause significant illness in persons with normally functioning immune systems. In people with AIDS, however, the infections become unusually aggressive and are often more difficult to treat. And they may result in death. In this section, we review the more common opportunistic infections.

PNEUMOCYSTIS CARINII PNEUMONIA (PCP):

The most common of HIV related infections, this is a parasitic infection of the lungs which usually appears as a dry cough (without producing sputum), shortness of breath, fever and chest pain. Diarrhea, night sweats and weight loss may also occur. The diagnosis may be strongly suggested by the chest x-ray, a low level of oxygen from a blood test called an arterial blood gas and on a nuclear medicine test called a Gallium scan. But definite proof of PCP is determined through a bronchoscopy which refers to passing a lighted tube through the mouth and into the airways to obtain a specimen for microscopic examination. Two-thirds of the people with AIDS have at least one bout of PCP. Treatment with antibiotics is successful in 75% of the cases, most commonly using Bactrim (trimethoprim-sulfamethoxazole) or pentamidine.

CANDIDIASIS:

This is a yeast infection which is called thrush when limited to the mouth but when the infection extends into the esophagus (the tube connecting the mouth to the stomach), it is called Candida esophagitis. The oral form is more easily treated with anti-fungal agents, like nystatin and ketoconazole and is believed to indicate a high risk of progressing to fully developed AIDS. The esophageal form, or any Candida infection of the lungs, bronchi or trachea, are sufficient for a diagnosis of AIDS in a person who has no other cause for immunodeficiency.

CRYPTOCOCCUS:

This fungal infection most commonly presents as a meningitis with fever and headache, occasionally as a stiff neck, changes in mental stability and seizures. It may also infect the lungs or bloodstream. The diagnosis requires a lumbar puncture (i.e., obtaining a sample of the fluid that surrounds the brain and spinal cord), and treatment must be continued for an extended period (four to eight weeks) and is successful in one-half to two-thirds of the cases.

TOXOPLASMOSIS:

This parasitic infection usually occurs in the brain and may cause seizures or other neurologic changes as well as fever and headache. The organism (*toxoplasma gondii*) is found in soil, poorly cooked meat and cat feces. Treatment may be quite lengthy and only partly successful.

TUBERCULOSIS (TB):

A sharp increase in this infection which is caused by the tuberculosis bacteria has been seen in recent years. Many of these cases are HIV related. When the infection goes beyond the lungs (so called extra-pulmonary TB), this qualifies for the diagnosis of AIDS in the person who is HIV positive. Symptoms of pulmonary TB include productive cough, fever, night sweats and weight loss usually over a period of weeks to months. A once or twice yearly skin testing program (using a TB bacteria extract called PPD or purified protein derivative) has been effective in identifying previously unsuspected cases of active TB as well as those individuals who have recently become skin test positive without further progression of the disease called "new converters". Treatment consists of combinations of oral medications and usually extends from twelve to eighteen months. Isolation of the person during the initial weeks of therapy is required only when the lungs are involved and the bacteria can be seen in the sputum of the infected individual. Adequate treatment usually renders the individual non-infectious within a short period of time, within two weeks in most cases.

MYCOBACTERIUM AVIUM-INTRACELLULARE (MAI):

These are also bacterial infections and, although related to TB, seldom occur in individuals without pre-existing lung disease or significant impairment of the immune system such as that caused by AIDS. The symptoms are similar to TB; however, treatment is usually required for a much greater period of time and with limited success in eradicating the infection from the body. Many people with MAI are on no treatment at all; and unlike classic TB, the bacteria is not a threat to people with normally functioning immune systems.

DIARRHEA:

This extremely common manifestation of AIDS may be caused by one or more of at least a dozen parasitic, bacterial and viral organisms which may remain unidentified even after the most aggressive investigation into the cause of the diarrhea. The diarrhea can be severe, leading to profound weight loss, volume loss (dehydration) and electrolyte and protein abnormalities. A work up aimed at isolating the causative agent may be time consuming, inconvenient for the infected person and uncomfortable but it is essential before therapy (i.e., antibiotics) which may be initiated. Many of these infections are treatable. If no agent is found, the person's symptoms may be a result of direct changes to the lining of the intestinal wall referred to as AIDS enteropathy.

MALIGNANCIES:

KAPOSI'S SARCOMA (KS):

This is a cancer which appears as purple-red raised lumps on the skin or inside the mouth. Prior to 1981, KS was an uncommon disease; the groups at risk were few and included: 1) elderly men of Jewish or Mediterranean extraction; 2) black Africans, particularly from Uganda and Zaire; and 3) cancer patients receiving immunosuppressive therapy. Only the second group was notable for younger persons with aggressive diseases. In the other two groups, the disease tended to be indolent or slow. In fact, individuals in the third group sometimes experienced regression of disease upon withdrawal of the immunosuppressive treatment.

Since the advent of AIDS, KS has become the most common related malignancy occurring in approximately one-third of the people with AIDS. Its cause remains unknown. Our discussion is limited to AIDS related KS.

One of the most distinguishing features of AIDS related KS when compared with the other types is that the disease tends to be widespread, involving many different sites in the body. That is, it is disseminated early in its course. The lesions are flat or slightly raised, violet/red, not tender or itchy and are usually round or oval. They occur anywhere on the body, including internal organs such as the lungs and intestine. Skin lesions are most easily noticed and are usually at the sites where biopsies are performed for a definite diagnosis. The tumor consists of an abnormal growth of blood vessels. Treatment is highly individualized and ranges from no treatment (for persons with one or few stable lesions) to a combination of chemotherapy and radiation therapy. Up to 75% of these individuals have shown a favorable response to therapy, depending on the tumor and the person's general condition. Ironically, chemotherapy for KS may increase the risk of developing opportunistic infections; therefore, it must carefully selected and monitored closely.

LYMPHOMA:

In general, lymphomas are cancers of the lymph nodes; they are classified according to the cell's origin (the lymphocyte). AIDS related lymphomas are notable for their rapid growth and their tendency to permeate the lymph nodes in a widespread manner at the time of diagnosis. Often what makes someone seek medical care are symptoms of fever, night sweats, weight loss and fatigue. Although these tumors begin in the lymph nodes, they may spread to other sites such as the intestinal tract, the brain, bone marrow or the heart. One particularly lethal form of lymphoma begins in the brain or spinal cord, called primary central nervous system (CNS) lymphoma. Tests for this include CT scans and lumbar punctures (spinal taps) although the diagnosis is often not made while the person is alive. Available treatments include various combinations of anti-cancer medications and are usually aggressive with many side effects. Even with treatment, survival is limited to less than one year.

OTHER HIV RELATED DISORDERS:

DERMATOLOGIC:

Skin problems are common among those infected with HIV. One such condition is a non-specific dermatitis (an inflammation of the skin), the onset or sudden exacerbation of which may herald the onset of an opportunistic infection. It typically appears as scattered 1-10 mm. red bumps which are raised and pruritic (itchy). Antihistamines such as Benadryl may provide relief of the itch. Chronic seborrheic dermatitis is another common skin manifestation. This usually presents itself as scaly, flaking skin, quite pronounced in the face and chest and often associated with severe dandruff. Some persons have repeated fungal infections of the fingernails and the feet, similar to athlete's foot, but more difficult to treat and cure because of the impairment of cellular immunity. Some of the other exanthemas (rashes) appear to result from auto-immune phenomena. This refers to the production of antibodies erroneously directed toward the "self", that is, one's own tissues. This antibody production occurs even in people whose immune systems are otherwise normal. Such immunopathic disorders account for a entire class of illnesses grouped together as the "autoimmune disorders". These include several well known disorders such as rheumatoid arthritis and systemic lupus erythematosus (SLE or lupus).

An example of another immunopathic disorder is immune thrombocytopenia (ITP) which is an abnormal destruction of one's platelets. (Platelets are essential elements in the blood necessary to stop bleeding). This occurs via production of antibodies directed against the platelets and often results in platelet counts one-fifth to one-tenth of the normal number. As a result, the person may experience easy bruising, nosebleeds, bleeding gums, etc. Through similar mechanisms, persons may experience decreases in the white blood cell count, called leukopenia, as well as in the red blood cell count (anemia). Not only does antibody-mediated destruction of these elements occur in the blood, but also HIV related abnormalities in the bone marrow production of these cells may contribute to the subnormal cell counts.

DEMENTIA:

The human immunodeficiency virus has been demonstrated to exhibit neurotropism, that is, an affinity for being taken up by and infecting the cells of both the central nervous system (the brain and spinal cord) and the nerves distributed throughout the rest of the body (the peripheral nervous system). The AIDS dementia complex is a somewhat more recently recognized disorder which probably affects most individuals with AIDS and a significant number of those who are HIV infected. The dementia especially attacks those who have survived with an infection for a long time. In children, however, developmental delays and school difficulties may occur as a result of the neurologic involvement.

The clinical pattern ranges from subtle changes in personality, memory, concentration, perhaps with depression and apathy, to a more advanced state which may exhibit hallucinations, severe gait impairment, other motor abnormalities and an inability to control bladder and bowel functions. In the early stages, a person may demonstrate an ability to compensate for the mild

deficits through such mental exercises as note taking, making lists, etc., in an attempt to improve their level of organization. The investigation into the cause of such neurologic changes is extensive and includes CT scan, lumbar puncture, a number of blood tests and a sophisticated neuropsychiatric testing. As the condition progresses, the person's appropriateness for their current living situation may need to be reassessed, often presenting the need for legal guardianship and placement in a chronic care setting.

MEDICATIONS:

In this section, we provide a list of those medications which are most commonly used in the treatment of HIV infection and related illnesses. Although the medications in the following table are limited to those which are used in somewhat more traditional medical practice, this is not to disregard the alternative therapies currently in use. Holistic therapies, acupuncture, meditation and various nutritional therapies are also of significant value to HIV infected patients, but are somewhat less likely to have undergone controlled clinical trials and are, therefore, not as commonly used by the traditional medical community. It must be remembered that the treatments for HIV related illnesses are highly individualized, therefore, what is appropriate for one patient may not be advisable for another individual, even one with the same type of infection or other illness. Multiple factors come into play, such as side effects, a history of drug allergies, or the patient's liver or kidney function. The medications are listed alphabetically; they are accompanied by their most common indications (the reasons for using the drug) and by their major side effects or toxicities.

<u>DRUG</u>	<u>INDICATIONS</u>	<u>SIDE EFFECTS</u>
Acyclovir	<i>Herpes simplex, zoster</i>	<i>Rash, kidney failure, low blood pressure, headache, nausea, sweating</i>
Amikacin	<i>TB, other bacterial infections</i>	<i>Kidney damage, hearing loss</i>
Amphotericin B	<i>Fungal infections, when widespread or severe</i>	<i>Chills, fever, low blood pressure, vomiting, phlebitis (damage to veins)</i>
Azidothymidine (AZT)	<i>Anti-viral, used against HIV</i>	<i>Decrease in red or white blood cell counts (approx. 1 in 5), nausea, headaches</i>
Bleomycin	<i>Kaposi's sarcoma, other cancers</i>	<i>GI distress, weight loss, lung damage, fever, chills</i>
Ciprofloxacin	<i>Bacterial infections (e.g., salmonella)</i>	<i>Nausea, vomiting, diarrhea, rash</i>
Clindamycin	<i>Toxoplasmosis, bacterial infections</i>	<i>Diarrhea, abdominal cramps, rash</i>

Clotrimazole	<i>Oral thrush (Candida)</i>	<i>Stomach upset, diarrhea</i>
Cyclophosphamide (Cytosan)	<i>ITP, lymphomas, lymphoid interstitial pneumonitis</i>	<i>Blood in urine, hair loss, lung damage, hepatitis, low white blood count, oral sores, nausea, vomiting</i>
Cycloserine	<i>TB/MAI</i>	<i>Rash, dizziness, seizures, confusion, slurred speech, tremor (shakes), depression, weakness</i>
DDA/DDC/DDI	<i>Anti-viral (against HIV)</i>	<i>Bone marrow depression, rashes, neuropathy</i>
PDHG	<i>CMV</i>	<i>Unknown</i>
Danazol	<i>ITP</i>	<i>Acne, increased body hair, deepened voice, hepatitis, rash, oily skin and hair</i>
Dapsone	<i>PCP</i>	<i>Anemia, hepatitis, decreases in white blood cell count, decreased platelets, nausea</i>
Dextran sulfate	<i>Anti-HIV</i>	<i>Unknown</i>
Doxorubicin	<i>Kaposi's sarcoma</i>	<i>Loss of appetite, diarrhea, bone marrow depression, heart failure, hair loss, nausea and vomiting</i>
Ethambutol	<i>TB/MAI</i>	<i>Headache, dizziness, gout, visual disturbances, nausea, vomiting, fever, abdominal pain, nerve inflammation</i>
Fansidar	<i>PCP</i>	<i>Rash, low white blood cell count, nausea, headache</i>

5-Flucytosine	<i>Cryptococcal infection</i>	<i>Kidney/liver damage, nausea, vomiting, diarrhea, rash, confusion, headache, sedation</i>
Gamma globulin	<i>ITP</i>	
Interferon alpha/beta/gamma	<i>Anti-viral (used with AZT)</i>	<i>Fevers, nasal congestion, weakness</i>
Isoniazid	<i>TB/MAI</i>	<i>Hepatitis, neuropathy, anemia, fever, memory loss</i>
Ketoconazole (Nizoral)	<i>Oral, esophageal candidiasis</i>	<i>Hepatitis, GI distress, light sensitivity, increase in breast tissue, itching, diarrhea</i>
Methotrexate	<i>Lymphomas</i>	<i>Headache, anemia, liver and kidney damage, mouth ulcers, light sensitivity, hair loss</i>
Nystatin	<i>Oral thrush (Candida)</i>	<i>Stomach upset, diarrhea</i>
PAS	<i>TB</i>	<i>Nausea, vomiting, fever, rash, hepatitis, anemia, goiter</i>
Pentamidine	<i>Pneumocystis carinii pneumonia (PCP)</i>	<i>Low blood sugar, low blood pressure, kidney damage, pancreatitis, decrease in white blood cells or platelets</i>
Pyrimethamine	<i>Toxoplasmosis</i>	<i>Loss of appetite, vomiting, hair loss, sore tongue</i>
Rifampin	<i>TB/MAI</i>	<i>Sore mouth, colitis, hepatitis, kidney failure, fever/rash, visual disturbance, gas, cramps, diarrhea</i>
Spiramycin	<i>Diarrhea</i>	<i>Rash, stomach upset, cramps</i>

Streptomycin

TB/MAI

*Hearing loss, low
potassium, kidney
failure*

**Trimethoprim
sulfamethoxazole
(Bactrim, Septra)**

PCP

*Kidney damage,
rash, fever, chills,
anemia, hepatitis,
diarrhea, light
sensitivity*

**Vinblastine/
Vincristine**

ITP, Kaposi's sarcoma

*Diarrhea, oral
sores,
headache, nerve
inflammation,
constipation,
diarrhea, depression,
rashes, gait
impairment, hair loss*

GENERAL INFECTION CONTROL

INTRODUCTION TO GENERAL INFECTION CONTROL:

Shelter life is difficult. It often means spending a lot of time in close quarters and having very little privacy or personal space. People living in shelters frequently sit and eat in a room with a lot of other people. They share the bathroom and sleep in bedrooms with people whose names they may never know.

Many people living in shelters have various medical problems or are in a weakened state of body for a number of reasons including poverty, alcoholism or age. Given the closeness that is such a part of shelter life, it is important that effective general infection control policies be developed and put to work.

The following recommendations can help to:

1. Provide a safer environment for guests, staff and volunteers.
2. Lower the risk of transmission of viral and bacterial infections among people living and/or working in a communal setting.
3. Protect individuals who are already weakened by age, substance abuse or a pre-existing medical condition or infection.

We must be aware that many illnesses are invisible in their early stages which, unfortunately, is when most contagious diseases are most easily spread. This means that very often we cannot tell when someone is ill simply by looking at him or her. Therefore, it is important that general infection control be practiced in all circumstances and at all times. Treating everyone with the same consideration and precaution also helps to minimize unnecessary labeling and discrimination against people who have an infectious disease.

Epidemics of any kind can create panic and anxiety in all of us. We constantly look for someone to "blame", and we tend to lose touch with our common senses. AIDS is no different. Dispelling the myths and irrational fears that can surround this disease is made more difficult by the many taboos that shadow open discussion of the primary modes of transmission of this virus -- sexual intercourse and sharing needles for IV drug use. In order to deal with this rising epidemic, we must realize and accept that HIV is not spread through casual contact. PWAs are not a threat to anyone who works with them or associates with them. Secondly, we must recognize that AIDS and HIV infection are preventable. We need to be aware of ways to reduce our risk of exposure to this virus both on the job and, more importantly, in our personal lives. Basic infection control measures are effective against HIV. By following them, you can minimize your risk of exposure in the work place to HIV and other viruses and diseases. *Outside of the job, you can protect yourself by using condoms for sexual intercourse and using clean needles if you choose to use drugs.*

We have divided this chapter into two basic sections:

1. Care of the shelter worker.
2. General infection control, including a discussion of infectious diseases and how they spread as well as specific recommendations for providing a healthy environment.

Throughout this section, we refer to "body fluids". This term includes *blood, semen, vaginal secretions, urine, feces, vomitus, nasal secretions, saliva, phlegm, pus, sweat, tears, amniotic fluid and breast milk.*

I. CARE OF THE SHELTER WORKER:

The best protection we as individuals have against any disease is to keep our bodies in as good health as possible. We are constantly being exposed to infectious diseases in our homes, at work, on the street and in stores. Our bodies have a natural defense system which we must try to keep intact. We can take care of ourselves by having a proper diet, getting regular exercise and rest, practicing good personal hygiene and getting immunizations which will boost our natural defenses.

At work, the last two ways of protecting ourselves are among the most important barriers that help prevent the spread of infection. *CAREFUL HAND WASHING* after contact with potentially infectious secretions along with proper handling of contaminated items are the most effective measure to prevent the spread of most infectious diseases. All blood and other body fluids should be handled as potentially infectious. If disposable gloves are available, they should be used when coming in contact with blood, semen or vaginal secretions and hands washed properly with soap and running water after disposing of the gloves. Hand washing alone is sufficient after touching urine, stool (feces), vomitus, tears, oral and nasal secretions.

Staff should wash hands with soap and running water:

- *before starting work*
- *before cooking/preparing food, eating, or feeding a child*
- *before (if possible) and after medical intervention*
- *after using the toilet or helping a child in the bathroom*
- *after changing a diaper*
- *after using a tissue or sneezing or coughing*
- *after any cleaning job.*

IMMUNIZATIONS help protect us against many serious diseases. Many of these diseases are common and relatively mild in childhood (e.g., measles) but can be quite serious in adults. We strongly recommend that each shelter worker know what his or her immunity or vaccine status is for the following diseases:

measles, mumps, rubella (German measles), polio, diphtheria, tetanus and influenza.

The diphtheria and tetanus vaccines require a booster shot every ten years. The influenza vaccine must be taken every year. Vaccines for measles, mumps and rubella or a single infection of these diseases provides a lifetime immunity to that particular disease, that is, you can only have these diseases once or you need only one vaccine for each to protect you.

Tuberculosis (TB) is a disease common in shelters. We recommend that each shelter be connected to the local Department of Public Health (DPH), so that the staff and guests can be tested at regular intervals (every six months) for exposure to TB. The skin test only shows who has been exposed to TB, not who actually has the disease. A chest x-ray can be taken in lieu of the skin test and is required after a positive skin test to determine if the TB is active or not. TB is treatable. In most cases, antibiotics can be taken before the infection is active. Early detection is the key.

SPECIAL SAFEGUARDS FOR PREGNANT WOMEN

Women of childbearing age should be aware that unborn children can acquire several infectious diseases. Such infections can cause miscarriage, birth defects or illness in the newborn. These infections include rubella, measles, mumps, Hepatitis B, cytomegalovirus, herpes and AIDS. The first four diseases can be prevented by immunization. Routine immunization (or other proof of immunity) is strongly recommended for the first three diseases:

measles, mumps and rubella.

In certain settings, an increased risk of Hepatitis B infection could exist. In those cases, vaccination is recommended. *Strict attention to hand washing and care with all blood and body fluids are the most effective safeguards for susceptible women against those infections for which there are no vaccines.*

THE EMPLOYER'S ROLE

We recommend that shelters maintain up-to-date medical records on all employees. Some organizations require pre-employment exams and regular medical check-ups. The purpose of the records is twofold:

1. To have easy access to information about pre-existing medical problems, medication and immunity status should a medical emergency arise on the job.
2. To help to protect other staff and guests from contagious disease that individuals may bring into the shelter (e.g., a staff member who was never exposed to chicken pox could catch it from his/her child and spread it at work before even knowing he/she was infected).

The following critical information should be included:

- *conditions that might require emergency care*
- *medications*
- *immunization status and history of childhood infectious diseases such as chicken pox and rubella*
- *if of childbearing age, immunity to cytomegalovirus (CMV)*
- *records of TB tests (skin test or CXR) and follow up if necessary*
- *next of kin*
- *name and phone number of primary doctor.*

The Massachusetts Department of Public Health recommends that, whenever possible, policies designed to protect against vaccine preventable diseases (measles, mumps, rubella, diphtheria, tetanus, polio) should be mandatory. Exceptions should be made for medical or religious reasons. In the event of a measles, mumps or rubella exposure, such an exempted susceptible worker may be legally excluded for at least one full incubation period.

Many staff members come to work when they are ill because of fear of lost pay or more often feelings of guilt due to inadequate substitute coverage. We recognize that finding and keeping dependable substitutes is difficult but upgrading substitute coverage is critical to a well run program. Personnel policies should be written to allow and encourage staff to stay at home when they are too sick to work.

All staff must make choices that balance their personal concerns and those of the shelter. However, there should be policies that outline when staff should not be at work. Adults with serious illnesses such as meningitis or chicken pox should not be at work. Adults with other contagious diseases (e.g., strep throat, impetigo) may return after treatment has begun. Adults with herpetic cold sores may work but must carefully practice personal hygiene. Adults with diarrhea should not work until well, or until a physician has determined that the diarrhea is not infectious.

It is the responsibility of each shelter to develop policies that not only work to protect staff and guests from illness but that also encourage staff to take care of themselves physically and emotionally.

II. GENERAL INFECTION CONTROL:

Infectious diseases are illnesses caused by viruses, bacteria, fungi or parasites that invade our bodies. They may or may not be contagious, that is, transmitted from one person to another. Contagious illnesses can be a major problem in shelters for guests, staff and volunteers. However, most diseases can be controlled. Every disease is spread in a specific way and so each can be put into one of four categories based on the mode of transmission:

1. Through the intestinal tract (intestines and feces).
2. Through the respiratory tract (eyes, nose, mouth and lung secretions).
3. Through direct contact (touching).
4. Through blood contact.

This section will first discuss various diseases according to the way they can be spread and how we can stop or minimize their transmission. Secondly, we will provide specific recommendations for maintaining a healthy environment at your shelter.

THE FIVE COMMANDMENTS OF INFECTIOUS DISEASE CONTROL:

I. PREVENT ILLNESS FROM SPREADING

Infections are spread from person to person by body fluids:

saliva, tears, nasal discharge, urine, stool (feces), phlegm, mucous, vomitus, blood, pus, semen, vaginal secretions and breast milk.

These secretions can be scattered around by sneezing or coughing, via dirty diapers, unwashed hands, used tissues, or they can get into food or drink.

Often infections are spread by people who do not look or feel sick. Viruses and bacteria like warm, wet and stuffy environments.

- A. TO PREVENT THE SPREAD OF INFECTION, KEEP THE SHELTER AND YOURSELF CLEAN.***
- B. HAND WASHING IS CRITICAL.***

This is perhaps the most important factor in infection control. Hands should be washed with soap and free running water, then properly dried with paper towels.

Adults should always wash their hands:

- *before beginning work*
- *before eating or preparing food, and helping children eat*
- *after changing diapers, toileting a child, or going to the toilet themselves*
- *after using a tissue on themselves or a child*
- *before (if possible) and after any medical intervention, e.g., cleaning a wound.*

We recommend that disposable gloves be used if available when handling the following body fluids:

- *blood or other fluids containing visible blood*
- *semen and vaginal fluids*
- *body tissues*
- *amniotic fluid (e.g., should a pregnant woman's "water" break).*
- *breast milk.*

N.B. : *Hands should be properly washed after disposal of gloves.
Hand washing alone is sufficient for the following unless they
contain visible blood:*

- *feces*
- *nasal secretions*
- *pus*
- *saliva*
- *sputum*
- *sweat*
- *tears*
- *urine.*

N.B. : *All diseases should be diagnosed by health care personnel.*

II. PREVENT ILLNESS BY IMMUNIZATIONS AND SCREENING

There are many vaccine preventable diseases. These are of particular importance in family shelters. The staff should encourage and help the families to ensure that the children complete all their immunizations as the disruption of family life most likely would affect the schedule of shots.

Tuberculosis (TB) screenings of guests and staff should be done every six months. Influenza shots should be available every year. Contact your local DPH for further information.

III. REPORT SOME ILLNESS

Certain diseases are required by law to be reported to the local Board of Health by the person making the diagnosis. This is important in preventing further spread of disease. The following table lists all diseases that must be reported.

Shelters should independently report any outbreaks, that is, three or more people (staff or guests) with the same disease. An epidemic (a large number of cases within a short period of time) of any disease, even if it is not on the list, should be reported. (See list, p. V. 9-V. 10.)

IV. EXCLUDE/ISOLATE SOME PEOPLE

There are very few illnesses for which people need to be isolated because of the health risks they pose for others. For most conditions, either the sick person has already exposed others before becoming visibly ill, or is not contagious after beginning treatment.

There are times when there is a health risk to other people at the shelter and isolation is necessary. In most cases, the person is ill enough to require hospitalization. Specific information is provided under the specific diseases.

A major consideration is the limitation of shelter life. Many shelters are not open during the day which means that a sick guest would not be able to get bed rest during the day. However, there are not many alternatives available, so individual shelters need to decide what their stand will be, and policies should be written stating what kind of care the shelter is capable of providing.

V. BE PREPARED

Do not wait until an epidemic hits. Do advance planning.

The staff must be educated about infection control. Insist on proper hand washing, cleaning and ventilation. This is the single most important way to prevent outbreaks of infectious disease.

Policies must be in place before a situation arises. The staff needs to know what to do if someone develops a contagious disease.

Each shelter should have a health consultant who knows about infectious disease and who works closely with the Department of Public Health.

MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH ABSTRACT
OF REPORTABLE DISEASE REGULATIONS (1985):

REPORTABLE TO LOCAL BOARD OF HEALTH:

Amebiasis
Animal Bite
Anthrax
Babesiosis
Brucellosis (undulant fever)
Campylobacter Enteritis
Chickenpox (varicella)
Cholera
Diphtheria
Encephalitis (specify type if unknown)
Epidemic Staphylococcal Infection of Newborn
Food Poisoning:
 a. *Botulism*
 b. *Mushroom and other poisonous vegetable and animal products*
 c. *Mineral or organic poisons as arsenic, lead, etc.*
 d. *Staphylococcal*
 e. *Paralytic shellfish poisoning*
 f. *Other*

Giardiasis
Haemophilus Influenzae Systemic Infection (without meningitis)
Hepatitis, Viral:
 a. *Type A*
 b. *Type B*
 c. *Type Non-A -- Non-B*
 d. *Undetermined*

Kawasaki Disease
Legionnaires' Disease (Legionellosis)
Leprosy
Leptospirosis
Listeriosis
Lyme Disease
Malaria
Measles (rubeola)
Meningitis:
 a. *Bacterial*
 b. *Viral*
 c. *Other*

Meningococcal Infection (without meningitis)

Mumps

Pertussis (whooping cough)

Plague

Poliomyelitis

Psittacosis

Rabies (human or animal)

Reye's Syndrome

Rickettsial Diseases:

a. *Rickettsialpox*

b. *Typhus*

c. *Rocky Mountain Spotted Fever*

Rubella (German Measles):

a. *Congenital*

b. *Noncongenital*

Salmonellosis (including typhoid and paratyphoid fevers)

Shigellosis (bacillary dysentery)

Tetanus

Toxic Shock Syndrome

Toxoplasmosis

Trichinosis

Tuberculosis

Tularemia

Yersiniosis

REPORTABLE DIRECTLY TO STATE DEPARTMENT OF PUBLIC HEALTH:

AIDS

Chancroid

Chlamydia Infection (genital)

Gonorrhea

Granuloma Inguinale

Herpes Neonatal

Lymphogranuloma Venereum

Ophthalmia Neonatorum:

a. *Gonococcal*

b. *Other agents*

Pelvic Inflammatory Disease

a. *Gonococcal*

b. *Other agents*

Syphilis

FACT SHEETS - INFECTIOUS DISEASES SPREAD THROUGH THE INTESTINAL TRACT:

WHAT ARE THEY?

These diseases are caused by germs (viruses, parasites or bacteria) that multiply in the intestines and then are passed out of the body in the feces.

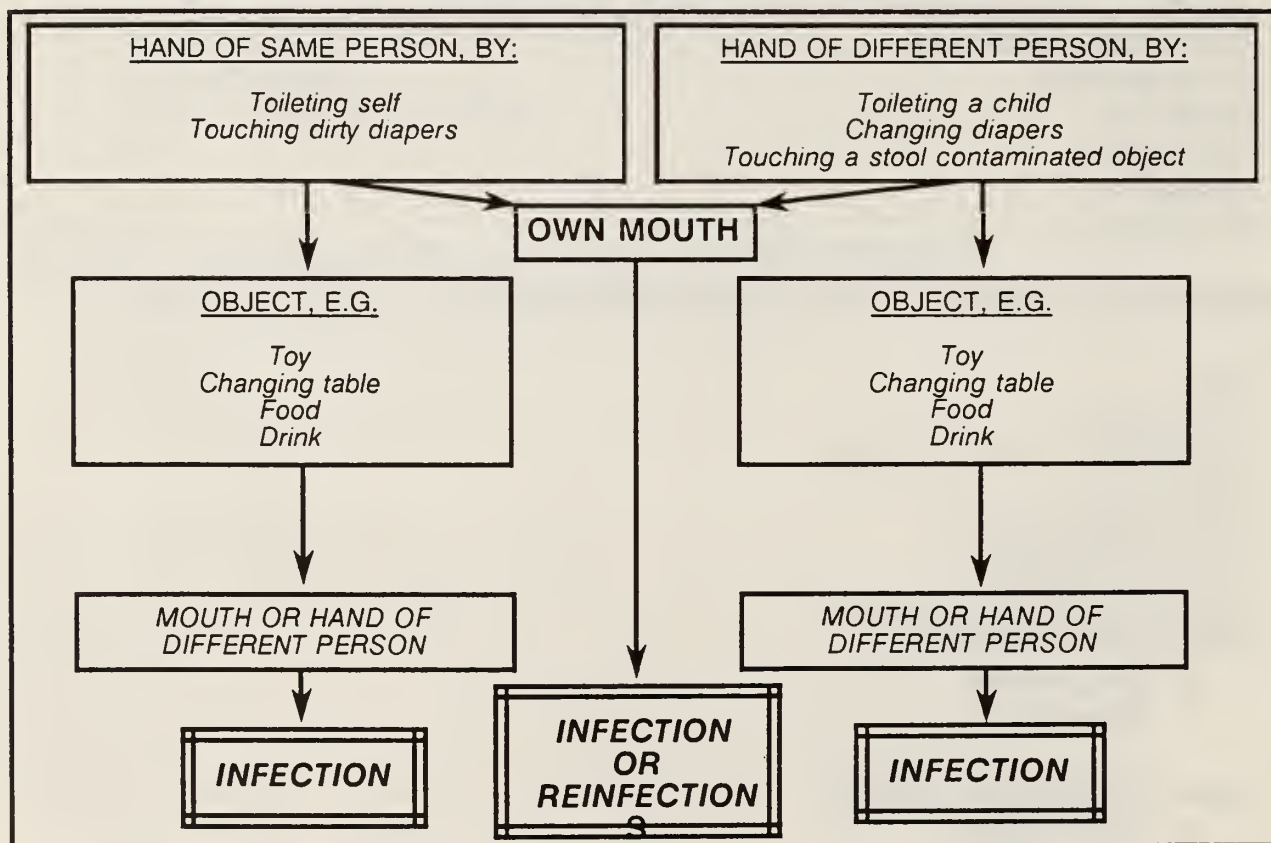
Common diseases spread through the intestinal tract are infectious diarrhea, pinworms, Giardia, shigella, salmonella, compylobacter and Hepatitis A.

WHO GETS THEM?

Anyone can catch diseases spread in this way, and with the exception of Hepatitis A, you can catch them again and again.

HOW DO PEOPLE GET THEM?

INFECTED STOOL WITH GERMS (MICROSCOPIC) (FECES):



Some infections begin by ingesting infected water or food, poorly cooked or raw meat, or unpasteurized milk. Compylobacter can be passed to humans by pets who have the bacteria in their feces.

HOW TO STOP THE SPREAD?

★ ★ HAND WASHING IS THE SINGLE MOST IMPORTANT WAY TO STOP THE SPREAD OF THESE DISEASES ★ ★

Hands should be properly washed especially:

- *after using the toilet or helping a child or baby with diapers or toileting*
- *before preparing or eating foods or feeding a child.*

Use disposable gloves, if available, when cleaning up obviously bloody stools.

Precautions might include a separate room or area with added staff attention for children who are sick.

Insist on general cleanliness at the center.

Dirty clothes should be stored separately in plastic bags and laundered as soon as possible.

HOW ARE THEY DIAGNOSED AND TREATED?

People with these germs in their feces may not act or feel sick or have diarrhea. Symptoms range from none at all to severe diarrhea to jaundice depending on the germ. Most intestinal tract diseases are diagnosed by stool cultures or by examining the feces under a microscope. Hepatitis A is diagnosed by a blood test.

Treatments vary from no medication to a course of antibiotics. While there is no cure for Hepatitis A, it is possible to prevent the disease by giving a protective shot within two weeks of exposure. Please refer to your health consultant for more information.

WHO SHOULD BE ISOLATED/EXCLUDED?

Most intestinal tract illnesses do not require exclusion as long as precautions are taken and hand washing and proper cleaning are strictly enforced. In severe cases of diarrhea, where the person is feeling very sick, it may be in his/her best interest to find a more comfortable alternative to the shelter.

Someone with Hepatitis A should be excluded until at least one week after the start of the illness and the fever is gone.

INFECTIOUS DISEASES SPREAD THROUGH THE RESPIRATORY TRACT:

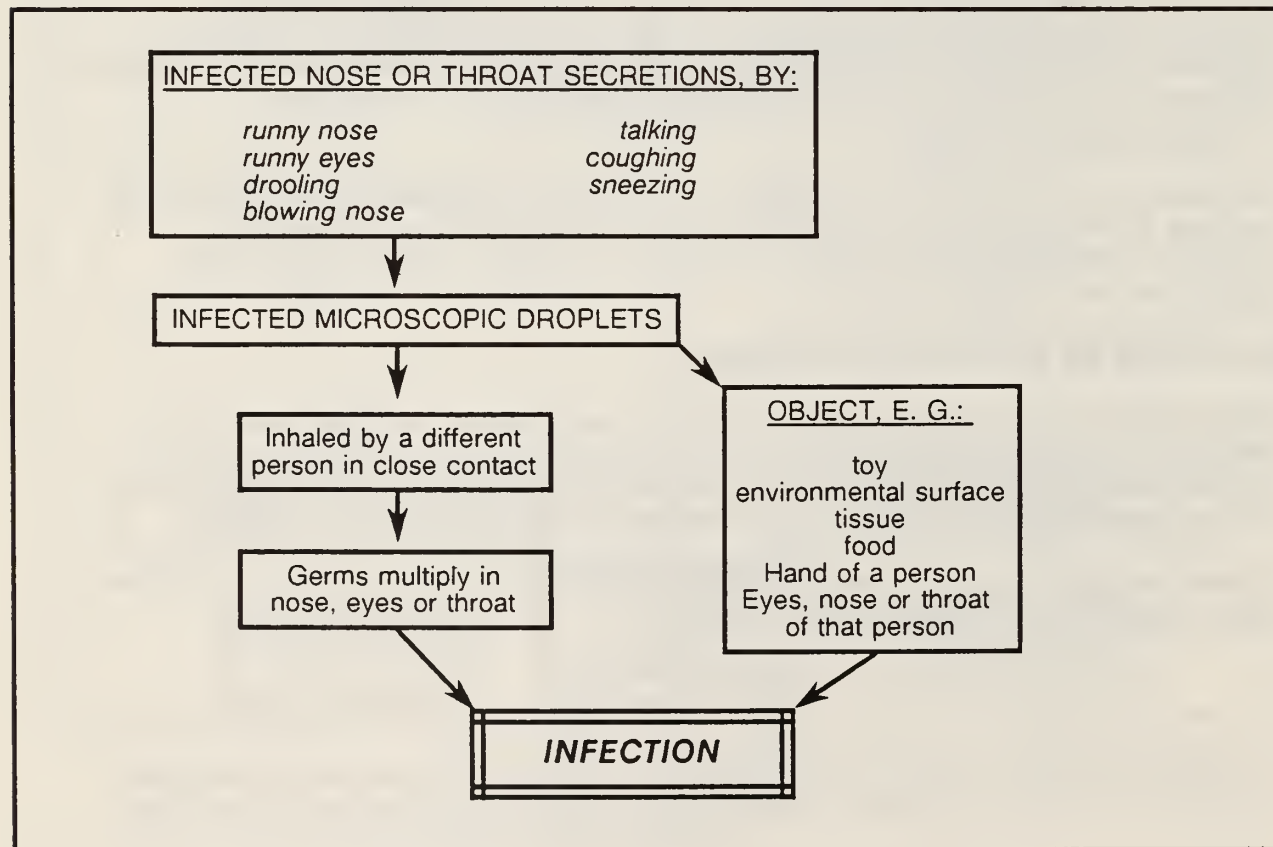
WHAT ARE THEY?

This varied group of diseases are spread through infectious droplets of nose, eye or throat secretions. They can cause mild, common illnesses such as viral "colds" and strep throat and also life-threatening diseases such as bacterial meningitis. Other diseases spread through the respiratory tract that are of concern in the shelters are tuberculosis (TB), chicken pox (and shingles) and haemophilus influenzae type B (HIB).

WHO GETS THEM?

Anyone can catch most of the these airborne diseases. Some are more common in children such as HIB (H.Influenzae type B), but it must be noted that adults can be infected with this bacteria, often with serious results. Chicken pox is another childhood disease; however, adults can get it and can be sicker than children with it. One infection of chicken pox provides lifetime immunity. Shingles is most common in adults as a person must have had chicken pox to develop shingles.

HOW DO THEY GET THEM?



HOW TO STOP THE SPREAD?

★ ★ GENERAL PRINCIPLES OF HAND WASHING AND CLEANLINESS IN THE SHELTER ARE ESSENTIAL (SEE SPECIFIC RECOMMENDATIONS.) ★ ★

1. Especially important are:
 - A. *Everyone should wash their hands after wiping or blowing noses; after contact with any nose, throat or eye secretions; and before preparing or eating food.*
 - B. *Mouthed toys should be washed and disinfected at least once daily, as should frequently used surfaces (such as tables).*
 - C. *Eating utensils should be carefully washed in hot, soapy water (dishwasher is best), disinfected and air-dried.*
 - D. *Disposable cups should be used. If this is not possible, each person should have his/her own cup which no one else ever uses. These cups must be washed in hot, soapy water after each use, not merely rinsed out.*
 - E. *The shelter should have fresh air and be aired out completely once a day, even in the winter.*
2. Everyone should learn to cough or sneeze toward the floor or to one side. If they sneeze or cough into a hand or tissue, they must properly dispose of the tissue and wash their hands. (See #5 below.)
3. Runny noses and eyes should be properly wiped; wash hands afterwards.
4. Disposable towels/tissues should be used.
5. Towels/tissues contaminated with nose, throat or eye secretions should be disposed of in a covered container with a plastic liner and kept away from food.
6. If there is a case of strep, anyone who develops a sore throat should consider getting tested for strep.
7. Chicken pox and shingles are contagious until the rash is crusted over and dry. Infected people should be isolated to minimize the spread of this disease. Please note that shingles is spread through direct contact but that you do not "catch" shingles. The danger is for anyone who has never been exposed to chicken pox. Such people can develop chicken pox from an exposure to shingles. Shingles may be latent in anyone who has had chicken pox and may develop at any time.
8. HIB vaccine is available for children between 18 months and 5 years of age. Please refer to your health consultant.

HOW ARE THEY DIAGNOSED AND TREATED?

Diagnoses are based on symptoms, cultures, and in the case of TB, a skin test and chest x-ray.

Treatment is often limited to relieving symptoms in the viral infections whereas bacterial infections (meningitis, strep, TB, HIB) are treated with antibiotics.

WHO SHOULD BE ISOLATED/EXCLUDED?

CHICKEN POX is highly contagious. *SHINGLES* is less contagious but can be serious. People with this virus should be excluded until the rash is crusted over and dry. This is especially important in shelters with older people and pregnant women.

MENINGITIS requires hospitalization for people infected with this disease. Close contacts may be carriers and should be excluded until they begin treatment. *HIB (H. Influenzae Type B)* often requires hospitalization.

TB. Anyone with active TB should not be in a shelter. The medications usually make a person non-contagious within a few weeks at which point the person may return under the condition that he/she completes the course of antibiotics.

INFECTIOUS DISEASES SPREAD THROUGH DIRECT CONTACT:

WHAT ARE THEY?

This group of diseases can be divided into two sections.

- I. Superficial (or skin) bacterial or viral infections and parasitic infestations. These are, in general, common and not serious. They include impetigo, ringworm, conjunctivitis, scabies and lice.
- II. Generalized (or total) body infections. These can be more serious. They can cause no illness, mild illness (like cold sores) or a total body illness. Some are treatable (e.g., syphilis), others are not (herpes). This category includes the major sexually transmitted diseases (gonorrhea, Chlamydia, syphilis, herpes, vaginitis).

WHO GETS THEM?

Anyone who has direct contact with infected secretions, infected skin or infested articles can develop these diseases/infestations. The germs that cause the generalized infections may stay in body secretions for months or years, even if the person appears totally healthy. These people may be carriers.

HOW DO YOU GET THEM?

These diseases do not spread unless there is direct contact with an infected person (skin, saliva, secretions), or with infected/infested clothes or objects of the person.

The germs that cause the generalized infections spread when an infected person's secretions (such as saliva or ooze from a sore) are able to penetrate the skin or mucous membrane of another person. This can happen through skin that is broken, cut or scraped, or through the thin membranes that line the mouth, eyes, nose, rectum and sex organs. The sexually transmitted diseases are usually spread through intimate sexual contact. These infections can also be transmitted from an infected mother to her newborn infant before or during birth.

HOW TO STOP THE SPREAD?

Since it is not always possible to know when these germs are in body secretions, every bodily secretion should be treated as possibly contagious. This means:

1. Hand washing is extremely important. Everyone should wash their hands well after any contact with blood, saliva, urine, stool, skin sores or genital secretions.
 - A. *Make sure everyone washes their hands after contact with any possible infectious secretions.*
 - B. *Use free flowing water for hand washing, not basins or stoppered sinks, which can become contaminated with the germs.*
 - C. *Liquid soap dispensers are preferable to bar soap.*
 - D. *Always use disposable tissues or towels for wiping and washing.*
 - E. *Never use the same tissue or towel for more than one child.*
 - F. *Dispose of used tissues, diapers, bandages or any disposable items stained with body secretions in a lined, covered container which is kept away from food and child care materials.*
 - G. *Toys should be washed and disinfected at least daily, and frequently used surfaces (tables, counters, furniture, floors) in the shelter should be washed or vacuumed daily.*
2. Each child should have his/her own crib or mat and should not switch. Sheets and mats should be kept clean and stored so that the sleeping surfaces do not touch each other. In adult shelters, it is ideal that guests sleep in the same bed each night.
3. No one should be allowed to share personal items such as combs, brushes, blankets, pillows, hats or clothing.
4. Sores, cuts or scrapes should be promptly washed and covered; eyes should be wiped dry.
5. Rashes, sores, running eyes and severe itching should be noted, and a health care provider should be seen, if necessary.

6. Surface areas (tables, floors, chairs, etc.) and toys that become stained with body secretions or blood should be washed and disinfected with bleach solution. Disinfecting surfaces contaminated with blood requires using the bleach solution of one part bleach to ten parts water. Remember to clean or dispose of cleaning items (mops, rags, towels, etc.) properly.
7. Do not permit aggressive behavior (biting, scratching).
8. Do not allow sharing of personal items that may have been contaminated with blood or other body fluids (toothbrushes, washcloths, teething rings).

HOW ARE THEY DIAGNOSED AND TREATED?

Many skin infections/infestations are diagnosed by the way they look. Treatments specific for the cause may be the use of anti-fungal creams, antibiotics or mite/lice killing lotions or shampoos.

The generalized infections may be more difficult to diagnose as many people show no symptoms. The germs can be cultured from infected fluids or examined under a microscope. Antibiotics are effective on some of these diseases. The viral infections (e.g., herpes) are more difficult to treat and may be recurring.

WHO SHOULD BE ISOLATED/EXCLUDED?

No one needs to be excluded for this type of infection. Women of childbearing age need to pay special attention to hand washing to minimize their exposure to cytomegalovirus (CMV) due to the possible negative effects of this virus on the fetus in the first three months of pregnancy.

DISEASES SPREAD THROUGH BLOOD CONTACT:

WHAT ARE THEY?

The two major blood borne diseases are Hepatitis B, a viral infection of the liver, and the AIDS/HIV infection.

These viruses are primarily found in the blood. Hepatitis B virus has been found in almost all body fluids; however, only blood and genital fluids and, to a lesser extent, saliva have been found to be infectious. HIV has been found in infectious concentrations in blood, semen, vaginal fluids and breast milk.

These diseases are both viral and both are preventable. (See medical section for a full discussion of HIV.)

WHO GETS THEM AND HOW?

These infections are much more difficult to catch or transmit from one person to another than any of the other diseases discussed.

The viruses that cause these illnesses can spread when blood or other body fluid that contains the virus enters the blood stream of another person. This can happen through the accidental or intentional puncture of the skin by a contaminated needle. Spread can also occur if infected blood comes in contact with a broken surface of the mucosa (such as the inside lining of the mouth, eyes, nose, rectum or sex organs). These infections can also be transmitted by an infected mother to her newborn infant. The virus is NOT transmitted by casual social contact such as hugging or handshaking or via food or water.

Once these viruses enter the body, they may stay for months or years, even if the person appears healthy. They can be spread by such a person, called a "carrier" of the germ, even if the person is not sick.

HOW TO STOP THE SPREAD?

1. All general procedures for hand washing and cleanliness at the shelter should be very carefully observed.
2. Carefully observe all the instructions for dealing with blood outlined under the specific recommendations. Since often you do not know who carriers are, it is wisest to always treat blood as a potentially dangerous fluid. With a known carrier of Hepatitis B, careful blood precautions must always be taken.
3. Do *NOT* allow sharing of personal items that may become contaminated with infectious blood or body fluids, such as toothbrushes, food or any object that may be mouthed.
4. Disposable items contaminated with blood or body fluid should be placed in plastic bags in covered containers.
5. Clothing or other washable items stained with blood and/or secretions should be stored separately until washed, or they should be bagged and carefully disposed of as soon as possible. Bleach as well as routine washing is recommended for clothing with blood or secretion staining.
6. Surfaces or toys contaminated with blood or body fluids should be cleaned with a bleach solution (one part bleach to ten parts water) as soon as possible. Objects may also be disinfected by boiling for ten minutes.
7. In general, discourage aggressive behavior (biting, scratching) at the shelter.
8. Gloves are preferred when cleaning blood spills. Wash hands well afterwards.
9. In the event of a specific infectious exposure to a person with Hepatitis B (such as a bite that causes bleeding), contact your local Board of Health and the exposed person's health care provider for advice on whether the exposed person should receive a preventive immune globulin infection and the vaccine series.

10. If the shelter cares for multiple children with Hepatitis B, a vaccination program for non-immune employees and children should be strongly considered. Discuss this with your health consultant.

WHO SHOULD BE ISOLATED/EXCLUDED?

There is no need for anyone with these viruses to be excluded from the shelters as long as they are able to take precautions with their body fluids and secretions. However, alternative living situations may be more comfortable for people who are very ill. As stated before, each shelter needs to decide how much medical care they are willing and able to provide.

SUMMARY:

I. THE FIVE COMMANDMENTS OF INFECTIOUS DISEASE CONTROL

1. *Prevent illness from spreading:*
 - *keep yourself and your environment clean*
 - *hand washing is very important.*
2. *Prevent illness by immunizations and screenings.*
3. *Report some illnesses.*
4. *Isolate/exclude some people.*
5. **Be prepared !**

II. HAND WASHING

Hands should be washed with soap and running water and properly dried with paper towels.

Hands should be washed:

1. *Before starting work.*
2. *Before preparing food, helping a child to eat or eating yourself.*
3. *After using the toilet, diapering a baby or toileting a child.*
4. *After using a tissue, sneezing or coughing.*
5. *After any cleaning job.*
6. *Before (if time allows) and after any medical intervention.*
7. *After removing disposable gloves.*

Disposable gloves should be used for handling:

1. *Blood and other body fluids containing visible blood.*
2. *Semen and vaginal fluids.*
3. *Body tissues.*
4. *Amniotic fluid.*

Hand washing alone is sufficient for handling:*

<i>feces</i>	<i>sputum</i>
<i>nasal secretions</i>	<i>sweat</i>
<i>pus</i>	<i>tears</i>
<i>saliva</i>	<i>urine</i>

(*Unless they contain visible blood.)

SPECIFIC RECOMMENDATIONS:

GENERAL PRECAUTIONS

1. *Wash hands frequently especially:*
 - *before preparing food, feeding a child or eating*
 - *before (if time allows) and after any medical intervention*
 - *after using the toilet, diapering a baby or toileting a child*
 - *after using a tissue, sneezing or coughing*
 - *after any cleaning job*
 - *after removing disposable gloves.*

Use soap and running water. Dry completely with paper towels.

2. *Wear disposable gloves (if available) when coming in contact with blood.*
Dispose of gloves immediately after use and wash hands.
3. *Try to keep hands away from face and mouth while working.*
4. *Know where to find the first aid kit and clean up equipment.*
5. *Clean frequently used areas after use.*
6. *Carefully dispose of all trash and waste matter in closed bags.*
7. **Use common sense !**

RECOMMENDED CLEANING MATERIALS:

In order to facilitate proper infection control and clean up of spills, the following items should be stored in designated areas which the staff can easily access:

1. *Disposable gloves.*
2. *Disposable wipe cloths and sponges.*
3. *"CHUX" or other disposable absorbent pads.*
4. *Paper towels.*
5. *Two types of disinfectant: A) Household bleach - dilute with water in a 1:10 ratio, e.g., 1 cup bleach in 10 cups of water. NOTE WELL: Bleach solution must be made ONCE A DAY to ensure effectiveness. B) 70% isopropyl alcohol.*

6. *Wastebasket that can be easily cleaned with soap and hot water.*
7. *Heavy duty plastic liners that fit the wastebasket.*
8. *Disposable thermometers or glass, oral thermometers with disposable sheaths.*
9. *First aid box containing gloves and a one way mask for CPR as well as basic medical supplies.*
10. *Liquid soap in dispenser.*
11. *Small metal scoop or dustpan and a metal scraper for cleaning up frequent/constant vomitus or fecal incontinence.*

REMINDER: Keep all cleaning materials out of reach of children.

STRUCTURAL RECOMMENDATIONS:

The following recommendations deal with the physical structure of the shelter. They reflect the "ideal situation" and some can be put into use with minor renovations or creative redesigning of existing space.

SPATIAL CONSIDERATIONS

- A. *All areas should be adequate for the number of people using them.*
- B. *A non-smoking area should be available.*
- C. *Avoid overcrowding.*
- D. *Handicapped bathrooms should be accessible.*

VENTILATION

- A. *All areas should be aired out daily, i.e., windows opened long enough to allow the air to circulate.*
- B. *Exhaust fans are highly recommended in both shower and toilet areas. This will help to dispel humidity and odors and increase the comfort of the guests as well as reduce the level of bacteria and viruses in the air.*
- C. *"Smoker-eaters" are recommended for rooms where there is a lot of cigarette smoking. They should be cleaned regularly and properly maintained.*
- D. *Temperature control is equally important. Cool areas should be provided in the summer especially for the very young and the elderly. Try to avoid*

overheating during the winter because the dry air which results in shelters can cause both physical problems and an uncomfortable living environment.

WATER

- A. *Clean running water should be available for washing and drinking. Bottled water should be available if water is unsafe to drink.*
- B. *Faucets that give a continuous stream of water and so allow you to wash both hands at the same time are preferred over those that must be held on while washing one hand at a time.*
- C. *Drainage of sinks and showers should be adequate for the volume of use and should be cleaned regularly.*
- D. *Temperature of bathing water should be carefully monitored if it is controlled from a main switch. If possible, showers should be designed so that the guests have control of the temperature of the water.*

SPECIFIC INFECTION CONTROL RECOMMENDATIONS:

INTRODUCTION

The following recommendations are specific cleaning procedures for infection control. They are listed in alphabetical order to make it easier to find a particular form of infection control.

Just a few reminders:

- 1. *THESE RECOMMENDATIONS ARE PROPOSED FOR THE CONTROL OF BACTERIA AND VIRAL INFECTIONS INCLUDING BUT NOT LIMITED TO THE AIDS VIRUS. In some instances, we make direct reference to the HIV infection but it is important to remember that this virus is easily killed and is hard to catch in the work setting, KEEP IN MIND THE WAYS THE HIV IS TRANSMITTED, i.e., the virus in infected blood, semen, vaginal secretions or breast milk must enter your blood stream. USE PRECAUTIONS WHEN THERE IS THE POSSIBILITY OF THESE BODY FLUIDS BEING EXCHANGED.*
- 2. *ALL COMMON AREAS (e.g., bathrooms, kitchens, sitting rooms) MAY BE SHARED.*
- 3. *BLEACH SOLUTION means bleach in water in a 1:10 ratio (1 cup of bleach in 10 cups of water). NEVER MIX BLEACH WITH AMMONIA OR OTHER HOUSEHOLD CLEANERS (like window or floor cleaners) OTHER THAN SOAPS OR DETERGENTS.*

ALPHABETIZED INFECTION CONTROL RECOMMENDATIONS:

BABIES' BOTTLES

- A. *Each mother should see that her child uses only his/her own bottle.*

- B. *Disposable bottles are preferable, but due to the high cost of these, plastic bottles are usually used by mothers living in shelters.*
- C. *Non-disposable bottles should be rinsed immediately after use to remove particles of milk or juice. They should then be washed with a bottle scrubbing brush in warm, soapy water and be placed on a rack to drain dry. If they can be safely placed in the dish washing machine, this type of washing is preferable after all milk particles have been removed with a bottle brush.*
- D. *According to the Governor's Task Force on AIDS Policies and Recommendations, ... "Bottle fed infants in general, and especially those with AIDS, should not be put to bed with a bottle of juice or milk because of increased opportunities for bacterial infection." This is not because the AIDS virus could be transmitted in this way but because of other infections that can be developed.*

BATH MATS: SHOWER AND FLOOR MATS

- A. *Rubber mats are recommended in areas of high use.*
- B. *Mats should be cleaned daily with bleach solution, and they should be allowed to dry completely.*
- C. *Mats should allow for proper drainage, and the floor beneath them should be cleaned and dried at least once daily.*
- D. *Disposable paper bath mats are also acceptable.*

BATHING AREAS: SHOWERS AND BATHTUBS

- A. *Clean at least once daily with bleach solution or heavy duty disinfectant.*
- B. *Allow to dry completely.*
- C. *When bathing children, clean tub immediately prior to use as well as after.*
- D. *A more thorough cleaning should be done on a regular basis (e.g., steam cleaning of the floors and walls).*
- E. *Encourage guests to use rubber thongs in the showers to reduce the spread of fungal infections such as athlete's foot.*

BATHROOMS

- A. *Bathrooms can be shared by all guests.*
- B. *In larger shelters, bathrooms should be swept several times a day.*
- C. *The following should be done at least once daily: floors swept and mopped with disinfectant, sink areas (including faucet handles) wiped with disinfectant or bleach solution and dried, toilets and toilet seats washed and disinfected.*

- D. *Encourage guests to clean up after themselves (e.g., flush toilets, dry sinks after use, properly dispose of used condoms, tampons, tissues, etc.).*
- E. *Toilet paper, paper towels and liquid soap should always be available in the bathrooms.*
- F. *Air fresheners and exhaust fans help to make bathrooms more pleasant.*
- G. *Dirty clothes should not be left in the bathroom.*

BITES

- A. *Children should be supervised at all times to prevent them from biting each other.*
- B. *Treat superficial bites and scratches the same way as cuts and abrasions. If the skin is not broken, the area is simply washed with soap and warm water.*
- C. *If the bite breaks the skin or is deep, the area is cleansed with a disinfectant such as hydrogen peroxide, then covered with sterile dressing. The child should be sent to a doctor as quickly as possible.*

BLEACH

- A. *Bleach should be used to clean up spills of blood. It has been shown to kill the HIV when used in a solution of 1 part of bleach to 10 parts of water.*
- B. *Bleach solutions should be made ONCE A DAY to ensure effectiveness. A spray bottle is handy and easy to use.*
- C. *Bleach should never be used full strength.*
- D. *Bleach is extremely poisonous and must always be kept away from small children.*

CLOTHING

- A. *Individual clothing should be kept clean and washed.*
- B. *Clothing contaminated with blood or other body fluids should be changed as-soon as possible.*
- C. *Blood stained clothing can be washed in hot water and detergent with chlorine bleach.*
- D. *Staff should wear gloves when handling clothes or other articles*
 - *that are blood stained*

- *that could be infested (e.g., by body lice) or may be contaminated by ooze from sores to reduce risk of exposure to disease spread by direct contact.*
- E. *Soiled clothing should not be given to another person to wear.*
- F. *Soiled clothing that cannot be washed immediately should be kept in closed, washable containers within plastic liners.*

COOKING AND SERVING AREAS

- A. *All cooking and serving areas should be washed with disinfectant and dried before and after use.*
- B. *Sinks should be wiped down to remove all food particles. The entire cooking and dining area should be washed with cleanser and dried after each use.*
- C. *Floors should be swept and mopped after each meal.*
- D. *Tables should be brushed and then washed with bleach solution before and after each meal.*

CPR -- (CARDIOPULMONARY RESUSCITATION)

- A. *At least one staff member on each shift should be trained and certified in CPR with the use of one way masks.*
- B. *One way masks should always be used for artificial respiration.*
- C. *These masks should be kept at easy access, and staff and volunteers should be aware of their location.*
- D. *One way masks should be thrown away after use and replaced by a new one.*

DIAPERS

- A. *Disposable diapers are preferred to cloth in the shelter setting.*
- B. *A diaper pail lined with a closed plastic bag should be kept wherever there is a young child (e.g., in the bedrooms, bathrooms and children's room). The pail should also be covered and located in a section where children cannot reach it.*
- C. *At least once a day, liners from diaper pails should be closed and emptied into another heavy plastic bag which is then sealed.*
- D. *Inexperienced mothers should be shown how to close properly the fasteners on the diapers so that there is no leakage.*
- E. *Cloth diapers or material used for burping babies should not be shared. They should be washed in hot water and detergent. Bleach should be added if the article has been soiled with blood.*

DILDOS/SEX TOYS

- A. Any sex toy found lying around should be handled with gloves.
- B. Carefully put them into a plastic bag and dispose of them in a closed container/trash barrel.

DISHES/EATING UTENSILS

- A. Use of disposable dishes and utensils is highly recommended (for environmental reasons, we recommend paper over styrofoam).
- B. Reusable dishes, utensils, pots, pans and serving dishes should be washed in a dishwasher that operates with water which is at least 180 degrees Fahrenheit or that allows for bleach to be added to the final rinse cycle.

DISINFECTING

Always wear gloves !!

A. Floors:

- Cover splash with something absorbent, like CHUX, which is then put in a plastic bag.
- 1:100 bleach solution or other disinfectant is poured on area of spill and left for 10 minutes.
- Area is then wiped up with paper towels, sponges or other absorbent material.
- These materials are disposed of in closed, plastic lined containers.

B. Walls:

- Wipe splattered area with sponge or wipe cloths soaked in bleach or other disinfectant.
- Dispose of wipes in plastic bag.
- Wipe infected area with sponge or wipe cloths soaked in bleach or other disinfectant.

C. Upholstery or rugs:

- Absorb the spills as given above for floors.
- Apply 1:100 bleach solution or 70% rubbing alcohol with a sponge.
- Dispose of cleaning materials in plastic lined closed container.

D. Mops:

- *After a mop is used to wipe up spills on floor, it should be disinfected with a 1:10 bleach solution or other disinfectant.*
- *Mop heads should be changed frequently.*

DRINKING FROM A COMMON SOURCE

- A.** *Discourage people from sharing bottles or drinking glasses as saliva borne diseases (e.g., strep throat) can be spread this way.*

DRINKING WATER

- A.** *Safe drinking water should be provided.*
- B.** *Bottled water dispensers are highly recommended as they ensure clean water and limit unauthorized access.*

FIRST AID BOXES

- A.** *Standard first aid boxes should be fully equipped and easily accessible to the following areas:*
- *living/common areas*
 - *dormitories*
 - *kitchen*
 - *children's playroom*
 - *bathroom/shower areas.*
- B.** *Gloves and one way masks should be kept in or by the first aid box.*
- C.** *Particular staff members should be made responsible for checking the boxes on a regular basis to make sure needed items are present.*

FOOD HANDLING AND STORAGE

- A.** *Wash hands before cooking or serving food.*
- B.** *All food handlers should be knowledgeable of proper storage of raw and cooked foods.*
- C.** *Refer to your licensing standards for more information.*

FRISKING

- A.** *Staff should always wear disposable gloves in shelters where frisking is routine. This will reduce exposure to diseases like scabies.*
- B.** *Take care when searching pockets or bags to avoid sharp articles.*

- C. *Should a staff member receive a cut or prick while frisking, the source of the wound should be determined. The wound should be properly cleaned and disinfected and any follow up action taken according to the policy of the shelter (see policy section).*

FEMININE HYGIENE PRODUCTS (SANITARY NAPKINS, TAMPONS, VAGINAL SPONGES, DISPOSABLE DOUCHES)

- A. *Disposable bags should be available and their use encouraged.*
- B. *These items should never be flushed down the toilet.*
- C. *Every woman should bag these items after use and dispose of them in a covered lined trash barrel.*
- D. *The use of douches is not encouraged unless medically prescribed.*
- E. *Gloves should be worn when cleaning up items which were not disposed of properly.*

HAND WASHING

- A. *Hand washing is important. Adults should wash their hands:*
- *before beginning work each day;*
 - *before preparing food, eating food, or helping babies and children eat;*
 - *after changing diapers, toileting a child or going to the bathroom themselves;*
 - *after using a tissue on themselves or a child or touching body secretions.*
- B. *Use free running water. Do not use stoppered sinks or basins for hand washing. The germs will easily move from one person to another. Liquid or powdered soap, individually dispensed, is better than bar soap.*
- C. *If absolutely necessary, individual towelettes may be used instead of soap and water. Any commercially available brand of towelettes is fine; they all contain alcohol as a moistener. Do not use diaper wipes as these usually contain oil and not alcohol.*
- D. *Use lotion on skin after washing hands.*
- E. *Paper towels are recommended for drying hands. Use towel to turn off the water instead of bare hands. If cloth towels are used, encourage the use of individual towels so the germs do not spread.*
- F. *Post a hand washing reminder above every sink (see sample).*

MOPS, SPONGES

- A. *Reusable mops and sponges should be washed with bleach and detergent after use.*
- B. *Squeeze as dry as possible and let air dry.*
- C. *Replace mop heads and sponges frequently.*

PERSONAL ARTICLES

- A. *Both adults and children should be advised not to share such personal articles such as needles, toothbrushes, razors, pierced earrings, hairbrushes and combs.*
- B. *Sharing of cups, bottles, eating utensils and food from another's plate should be avoided by adults and children. This is not because the AIDS virus could be transmitted in this way but because other contagious diseases may be transmitted.*

POTTIES AND TOILETS

- A. *Small children should use their own individual potty chair.*
- B. *Potties should be emptied and rinsed immediately after use.*
- C. *They should then be washed with soap and warm water and disinfected with 1:10 solution of bleach or other disinfectant.*
- D. *Clean and disinfect the sink after washing the potty.*
- E. *When possible, have a separate slop sink for washing the potty.*
- F. *Toilets (seats, rims, bowls) should be kept clean and disinfected with 1:10 bleach solution at least once daily using a toilet brush to remove all particles of feces or vomitus.*
- G. *Toilet brushes should be washed in disinfectant at least once daily.*

PREGNANCY

- A. *Pregnant staff members and guests are not at risk for the HIV infection through casual contact. Like everyone else in the shelter, they should use the necessary precautions when handling all body fluids such as blood or material contaminated with feces or vaginal secretions.*
- B. *Immunizations: The Center for Disease Control recommends that adults who work in day care centers (and this would seem to apply also to family shelters) should be immunized against diphtheria, tetanus, polio, mumps, measles and German measles (rubella).*

- C. *Rupture of membranes: When a pregnant woman's membranes have ruptured (her bag of water has broken), delivery should normally occur within 24 hours. She should be sent to her doctor or the hospital as quickly as possible.*
 - *The leakage of fluid in the mother's membranes may flow onto bedding, couch or on rugs. These should be cleansed in the same manner as instructed under blood disinfection. A person assisting the mother at that time should wear gloves if possible. If not, they should wash their hands thoroughly after contact.*

RAZORS AND RAZOR BLADE DISPOSAL

- A. *Razors should never be shared.*
- B. *Razors should be capped for storage by the individuals using them.*
- C. *We recommend that a separate, puncture resistant, closed container or cardboard box be used for the disposal of used razors and blades.*

SHEETS, TOWELS AND OTHER HOUSEHOLD ITEMS

- A. *These items should be washed in hot water and detergents. Chlorine bleach may be added in articles that are soiled with blood or other body fluids.*
- B. *People who strip the linens off the beds and who work in the laundries (i.e., handling used linens and towels) should wear gloves to reduce their exposure to disease spread through direct contact (e.g., scabies, shingles).*

SHOWER CURTAINS

- A. *Rinse daily with bleach solution. A spray system is helpful.*
- B. *Allow to dry completely after cleansing.*
- C. *Curtains should be of good quality and come treated with an anti-mildew substance.*
- D. *Shower curtains should be washed in a machine with soap, bleach and warm water (or according to manufacturer's directions) at least once a month.*
- E. *Shower curtains should be replaced on a regular basis.*

SALIVA/SPIT

- A. *There is no documentation of any cases of HIV transmission through saliva.*
- B. *Wash skin with soap and warm water as soon as possible after being exposed.*

SOAP

- A. *Liquid soap is recommended over bar soap.*

SYRINGE NEEDLES

- A. *Used needles, whether from clinical or illegal use, should be disposed of in puncture resistant containers (e.g., biohazard containers or a cardboard box).*
- B. *Do not recap needle by hand.*
- C. *Do not remove needles from disposable syringes.*
- D. *Do not bend or otherwise manipulate used needles by hand.*
- E. *Should a staff member receive a needle prick, wash puncture wound with soap and running water for 3-5 minutes. Disinfect with hydrogen peroxide or iodine. Follow up medical care and precautionary tests should be done according to the policy of the individual shelter.*

THERMOMETERS

- A. *We recommend the use of disposable sheaths with glass oral thermometers.*
- B. *Thermometers should be soaked in disinfectant or bleach solution for at least 10 minutes. In the absence of disinfectant, use alcohol (70% isopropyl alcohol).*
- C. *Always rinse with COOL water and dry before storing.*
- D. *Electronic thermometers come with special sheaths. Wipe probe with alcohol or clean between uses according to the manufacturer's directions.*

TOILETRIES

- A. *Razors, toothbrushes, combs, towels and washcloths should never be shared.*
- B. *Such items should not be stored in shared compartments after use.*

TOYS

- A. *A toy that has been in a child's mouth should be washed before another child handles it.*
- B. *A stuffed toy used by several children should be washed weekly or more frequently if it becomes very soiled.*
- C. *Hard surfaced toys should be washed daily.*

TOWELS

- A. *Paper towels are recommended for hand drying.*
- B. *Individual bath towels should be available.*
- C. *Towels should be laundered as soon as possible after use.*
- D. *Adequate drying space should be available for re-used, individual towels.*

TRASH BARRELS

- A. *Trash barrels should be large enough for volume of use.*
- B. *They should be lined or double lined with plastic garbage bags.*
- C. *They should be emptied frequently. Bags should be tightly closed before removing from their container and should be stored in a safe place awaiting permanent disposal.*
- D. *Trash barrels should be kept covered and guests should not be allowed to sort through the trash because there may be used needles, tissues and other infected material in the rubbish.*
- E. *The insides of the barrels should be washed and dried several times a week.*

VAGINAL SECRETIONS

- A. *Gloves should be used when handling pads or items contaminated with vaginal secretions.*
- B. *Soiled clothing or bedding should be washed in hot water and soap and a cup of bleach should be added to the final rinse.*

WOUNDS

If time allows, wash hands and/or put on a pair of disposable gloves before administering wound care. Be sure to wash your hands after care has been administered.

FIRST AID

- A. *Abrasions are caused by rubbing or scraping off the skin or mucous membrane. They are easily infected and need thorough cleansing with soap and water, removal of all dirt particles and application of an antiseptic. Abrasions should then be covered with a sterile dressing.*

- B.** *Wounds caused by a sharp object such as a knife, razor or broken glass, tend to bleed freely which helps to wash out infective materials. Bleeding should be stopped by applying pressure to the area with a sterile compress (pad of gauze). According to the severity of the cut, the patient should be sent to a doctor, or the cut should be cleansed around the edges, outward from the wound, using a clean gauze pad for each stroke. An antiseptic, such as Betadine type solution, can then be applied, and the wound covered by a sterile gauze pad or Band-Aid, depending on its size.*
- C.** *Puncture wounds are those caused by something with a sharp point such as a nail or a needle. They are very likely to become infected because they do not bleed freely. As there is risk of tetanus or other infection developing, the child should be sent to the health care provider or nurse. The mother should bring the child's immunization record showing the date of his/her tetanus booster.*

COUNSELING ISSUES:

This section provides some information that may aid you when counselling a guest.

CLEANING WORKS (HOW TO)

- A.** *Use a 1:10 bleach solution or straight (full strength) bleach.*
- *Pull solution into syringe through needle, shake well, squirt out bleach.*
 - *Do this twice.*
 - *Pour out bleach solution. RINSE WORKS TWICE, using running water.*

See attached sample.

SAFER SEX

See attached pamphlet (AIDS Action).

TATTOOS

Shelter guests should be advised not to have tattoos done to themselves or their friends. The needles used for making tattoos are not always cleaned after use; and therefore, they may pass blood particles from one person to another.

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TABLE OF INFECTIOUS DISEASES BY MODE OF TRANSMISSION

MODE OF TRANSMISSION	EXAMPLES	WHO GETS THEM ?	HOW DO WE GET THEM ?	PRIMARY WAYS ? TO STOP SPREAD	ISOLATION / EXCLUSION*
INTESTINAL ... TRACT Germs multiply in the intestine, passed out of body in feces	Pinworm Infectious diarrhea Salmonella Hepatitis A	Anyone	Infected stool hand mouth	WASH HANDS	Hepatitis A
RESPIRATORY TRACT Infectious droplets from nose, eye, throat get dispersed	Colds Strep throat Chicken Pox Meningitis	Anyone	Infected droplets air object another person	WASH HANDS Cough and sneeze properly Good ventilation	Meningitis Active TB Chicken Pox
DIRECT CONTACT Germ lives on skin or in sores on skin	Impetigo Lice Cold Sores Syphilis	Anyone	Direct contact with infected skin or material. Some require intimate sexual contact for transmission.	WASH HANDS	NO
BLOOD CONTACT Blood borne virus	Hepatitis B AIDS - HIV	Anyone	Infected blood or body secretion enters blood stream of another e. g. via unprotected sex or puncture of skin with contaminated needle.	Avoid blood to blood contact Use condoms Do not share works	NO

* SEE EACH SECTION FOR PARTICULARS

GLOSSARY OF AIDS TERMS

AAC:

AIDS Action Committee.

Acquired Immune Deficiency Syndrome (AIDS):

A condition that reduces the person's ability to fight disease, leaving it vulnerable to infections.

Aerosolized Pentamidine:

Alternative treatment for PCP. Eliminates many of adverse systemic side effects, because the pentamidine is inhaled directly into the lungs. Still in the experimental stage.

AIDS-Related Complex (ARC):

ARC patients have some symptoms of AIDS, but not the "full-blown" (or "frank") disease. Symptoms may include unexplained swollen glands or fever, weight loss, or persistent diarrhea.

Amphetamines:

A class of CNS stimulants; incl. Benzadrine, Methadrine.

Anal Intercourse:

Insertion of the penis into the rectum of either men or women.

Angel Dust:

Slang for PCP.

Antibody:

A unique protein produced by blood plasma cells to counteract or kill some specific infectious agents - viruses and bacteria.

Antigen:

A substance that is foreign to the body and stimulates the formation of antibodies to combat its presence.

Asymptomatic "Carrier":

A person who has had an infectious organism within the body but feels or shows no outward symptoms.

AZT:

Deoxyuridine. Investigative drug with severe side effects. It inhibits viral replication. Used in treatment of + HIV.

Bactrim:

An antibiotic that combines sulfa and trimethoprim used for lung and urinary infections.

Bag:

A unit of measure: 1/4 gram, \$20-\$30.

Balloon:

A unit of measure similar to a bag.

Barring:

A process by which a guest is denied services of a given shelter, because of a rules infraction.

Base:

To smoke a specially prepared form of cocaine in a water pipe; a very fast and addictive high.

Belushi:

(after John Belushi) a speedball, alternative injections of cocaine and heroin.

Benzadrine:

"Bennies"; a popular form of amphetamine.

Blow Job:

Insertion of the penis into the mouth of a woman or a man (also known as "giving head").

Boost:

To inject drugs; also to steal.

Boot:

To draw up blood into syringe and mix with substance, usually cocaine.

Boy and Girl:

Heroin and cocaine.

Bronchoscope:

An optical instrument used to examine the breathing tubes of the lungs (airways).

Candidiasis:

A yeast-like infection caused by *Candida albicans* which affects mucus membranes (skin and internal organs). Oral infections are called thrush and exhibit creamy white patches of exudate on inflamed and painful mucosa. Common sites are the nailbeds, axilla, umbilicus, around the anus, and the esophagus. It may occur systemical and affect the heart and the lining around the brain and spinal cord. This infection has become a standard problem seen in immune depressed people. It occurs frequently in the vaginal area where it is not associated with AIDS.

CDC:

Center for Disease Control.

China White:

Previously, a high-grade heroin; now slang for *Fentanyl*.

Chipping:

Mixing other drugs with methadone.

Clean, Clean Up:

To be drug free; to stop using.

CMV:

Cytomegalovirus - a virus related to herpes. Infection can occur without symptoms or result in flu like symptoms of aches, fever, sore throat, weakness or enlarged lymph nodes. Symptoms could be severe in pregnant women or immune-suppressed people. Usually is mild and self limiting.

CNS:

Central nervous system.

Cocaine:

A short-acting stimulant in the form of a white crystalline powder; it can be injected, inhaled, or smoked.

Coke:

Cocaine.

Cold Turkey:

Abrupt withdraw of drugs.

Condom:

A latex barrier which is placed on an erect penis prior to sexual contact (also known as rubbers, safes, trojans, raincoats, etc.).

Cooker:

A bottle cap or spoon used to heat and dissolve heroin in water.

Cotton:

Heroin and other drugs are drawn into the syringe through a piece of cotton for filtration; well used cottons are boiled during scarce times.

Crack:

A form of cocaine prepared for smoking.

Crank:

Amphetamines.

Crashing:

A state of physical discomfort and depression caused by stopping speed use, esp. after an extended period of use.

Crystal:

Amphetamines; particularly methamphetamine.

Cum:

The ejaculatory fluid which results from a sexual climax.

Cut:

A substance added to a drug that acts as an extender.

Dementia:

Loss of memory functions.

Dental Dam:

A rubber sheath placed over the tongue for oral-vaginal or oral-rectal sex.

Depression:

A mental illness consisting of a dejected mood, apathy, insomnia, weight loss, and physical inactivity.

Detox:

Medical management of withdrawal from heroin; usually refers to 21 day methadone treatment.

Dilaudid:

Prescription synthetic morphine.

Dillies:

Prescription synthetic morphine; *very addictive*.

Dirty:

Using heroin or speed, esp. after being clean.

Downers:

Opiates or barbituates.

Eight Ball:

1/8 ounce of cocaine; street value \$250.00.

ELISA (Enzyme Linked Immunosorbent Assay):

A method to detect and measure protein in blood serum and body fluid, using immunological techniques. It is the first test usually used to look for HIV antibodies in the blood. If this test is positive, next test to confirm results for HIV antibodies is *Western Blot*.

Encephalopathy:

Disorder of the brain, with varying degrees of memory loss and confusion. Often associated with A.I.D.S. (formerly referred to as A.I.D.S. dementia).

Epidemiology:

The study of relationships among various factors thought to determine the frequency and distribution of diseases in humans.

Exposure:

The act or condition of coming in contact but not necessarily being infected by a pathogenic agent.

Fentanyl:

Synthetic heroin; made in home labs, sometimes improperly, resulting in physical trauma.

Fisting:

Putting a hand or fist into someone's rectum or vagina.

Fix:

To inject drugs, esp. heroin; an injection of drugs.

Freebase:

To smoke a form of cocaine in a water pipe; a smokable form of cocaine.

Gallium Scan:

A radioisotope (Gallium) is injected into a vein. A camera (scan) picks up the radioactive isotope that is taken up by the white blood cells (WBC). Results would show a large concentration of Gallium wherever there is a large collection of WBC. A large collection of WBC usually means an infection is present.

Getting Off:

To get high; the initial awareness of pleasure from injection.

Guest:

A person who seeks the services of a shelter (client, patient, etc.).

Guzzel:

To inject drugs, usually heroin.

Hemophillia:

A hereditary blood condition found in males in which even minor bodily injuries can be followed by prolonged bleeding.

Hepatitis A:

A virus that affects the liver. Contagious in feces, i.e. toilet waste goes into ocean and shellfish are contaminated; then a person eats the shellfish and gets hepatitis A. Usually called "infectious hepatitis."

Hepatitis B:

A virus that affects the liver. Contagious in blood, saliva, and feces. Usually passed on sharing needles or anal-oral sex.

Heroin:

Substance derived from morphine.

Herpes Simplex Virus II (HSV II):

Causes painful sores on the anus or genitals, but can be transmitted to the face or mouth.

HIV-Antibody Test:

A test performed on all donated blood that reveals the presence of antibodies to HIV. If antibodies are detected, they are presumed to have been exposed to the virus and are considered to be infected. An infected person can also transmit the virus to others.

HIV Positive:

Human Immunodeficiency Virus that infects the white blood cells (WBC) suppresses the immune system.

Holistic Medicine:

Medical care that treats a person as a "whole" and takes into consideration the physical, emotional, social and economic aspects of each individual life. It may incorporate non-traditional medical practices such as acupuncture.

Horn:

To snort/sniff; usually refers to stimulants.

Hospice:

A facility or program designed to provide a caring environment for supplying the physical and emotional needs of the terminally ill.

Human Immunodeficiency Virus (HIV):

The virus that causes AIDS, formerly referred to as LAV or HTLV-III.

Immune System:

A system within the body that helps the body resist disease- causing organisms such as germs, viruses, or other infections.

Immunosuppressed:

A state of the body when the immune system defenses do not work normally - usually as a result of illness or the administration of certain drugs used to fight cancer or prepare the body to accept transplanted donor organs.

Incubation Period:

The interval between infection and appearance of the first symptom. (See *Latency*.)

Infected:

The state of the body when a part of it has been invaded by a pathogenic agent that ordinarily multiplies and causes harmful effects.

Intravenous Drugs:

Drugs injected by needle directly into a vein.

ITP (Idiopathic Thrombocytopenia Purpura):

Cause unknown; platelet count is lowered, resulting in bruises.

Kaposi's Sarcoma (KS):

A tumor of the walls of blood vessels. Usually appears as pink to purple, painless spots on the skin but may also occur internally in addition to or independent of the skin lesions. Death occurs from major organ involvement. Originally seen in elderly men or in equatorial Africa as a slow growing, benign lesion, it is now occurring in young people and is rapid and frequently fatal in its course.

KJ:

"Killer joint," marijuana cigarette with PCP.

Latency:

A period when the virus is in the body but rests in an inactive, dormant state. (See "Asymptomatic.")

Leukoplakia:

A change in the lining cells of mouth, nose, or vagina; maybe pre-cancerous; appears as white patches. Must be diagnosed as different from thrush.

Lubricant:

An agent used to decrease bruising that occurs during anal or vaginal intercourse. (Water-based lubricants, such as K-Y Jelly, are recommended).

Lymphadenopathy:

Persistent swelling of the lymph nodes. In AIDS, a condition of long-term generalized lymph-node swelling characteristic of the so-called AIDS-Related Complex.

Lymphocytes:

Specialized white blood cells involved in the immune response.

Lymphoma:

Cancer of the lymph glands.

Meth:

Slang for Methamphetamine as well as for Methadone.

Methadone:

Legal synthetic heroin substitute; very addictive, intensely painful withdrawal cycle; dispensed through government programs.

Methadrine:

Brand name of methamphetamine.

Methamphetamine:

Currently the most available form of amphetamine.

Mexican Brown:

Form of heroin originally of high quality; currently, heroin that has been "cut" with brown sugar.

Morphine:

Derived from opium; available by prescription.

Needle:

Usually refers to the entire syringe/needle combination.

Nod, Nodding:

A state of dreaminess induced by heroin.

Nonoxinol:

A spermicidal agent which destroys HIV.

OD:

Overdose; ranges from unconsciousness to death.

Opportunistic Infections:

Those diseases that are caused by agents that are frequently present in our bodies or environment but which cause disease only when there is an alteration from normal healthy conditions such as when the immune system becomes weak or damaged.

Outfit:

Syringe/needle.

Overamp:

Overdose of speed, usually in the sense of too intense sensation.

PAIDS:

Pediatric AIDS.

Pathogen:

Any disease-producing microorganism or substance.

PCP:

Hallucinogen, originally a battlefield anesthesia; currently a horse tranquilizer.

Pellets:

Slang for ritalin.

Pentamidine:

An anti-parasite medication to treat toxoplasmosis pneumocystis; usually given in IV. New form is in spray (aerosolized).

Perinatal:

Occurring in the period before, during, or after birth.

Persian:

A form of heroin; very addictive, difficult withdrawal.

Persistent Generalized Lymphadenopathy:

Continuous enlargement/swelling of the lymph nodes.

Pneumocystis Carinii Pneumonia (PCP):

A lung infection seen in immunosuppressed people. It is caused by the protozoa *Pneumocystis carinii* present almost everywhere but which is normally destroyed by healthy immune systems. It is airborne. Once a person develops PCP they are susceptible to reoccurrence of the disease and the outcome is often fatal.

Point:

Syringe/needle.

Prevalence:

The total number of persons in a given population with disease at a given point in time - usually expressed as a percentage.

Prognosis:

Prediction of course and end of a disease and outlook based on these factors.

Raw:

Synthetic heroin, very strong.

Redi-Rock:

A small piece of specially prepared cocaine, often inserted in a cigarette for instant availability.

Reds:

Slang for barbituates, usually seconal.

Remission:

The lessening of the severity or duration of disease, or the abatement of symptoms altogether over a period of time.

Rig:

Syringe/needle.

Rimming:

Oral anal contact.

Ritalin:

A stimulant in pill form; not a member of amphetamine family.

Rock:

A solid piece of cocaine.

Run:

To inject drugs; ON A RUN using IV drugs continuously.

Rush, Rushing:

The initial intense sensation felt when injecting drugs.

S & M:

(Sado-masochism) inflicting or receiving pain, cuts, abuse, etc. to or from another.

Script:

Prescription.

Seropositive:

Producing a positive reaction to a blood test - the HIV antibody test(s).

Shoot Up:

To inject drugs.

Sick:

The intensely painful period during withdrawal from opiates.

Skin Popping:

Superficial injection of drugs.

Slam:

To inject drugs.

Slim Disease:

HIV wasting syndrome. Profound involuntary weight loss.

Smak:

Slang term for heroin.

Snort:

Inhalation of a substance via nostrils; i.e. cocaine, crystal, Persian heroin.

Speed:

Amphetamines.

Speedball:

Mixing together cocaine (or speed) and heroin in a syringe.

Speed, Speeding:

Amphetamines, using amphetamines.

Spoon:

A utensil for dissolving and heating substances before injecting.

STD:

Sexually transmitted diseases.

Stick:

To inject drugs.

Strung Out:

Heavily addicted.

Stuff:

Heroin.

Syndrome:

A set of signs and symptoms that occur together, resulting from a common cause or appearing, in combination, to present a clinical picture of a disease.

T Cells:

Lymphocytes that mature in the thymus and that mediate cellular immune reactions.

Tar:

A dark brown form of heroin from Mexico.

TB:

Tuberculosis - infection of the lungs. Highly contagious. Symptoms are lingering cough, weight loss and night sweats.

Thrush:

White patches usually in mouth, esophagus, or vagina (can be in other mucous membrane). Also called Candida.

Toxoplasmosis:

Caused by a parasite that infects the central nervous system and other organs in immune suppressed persons or pregnant women. Cats can acquire this disease and infect the litter box. Symptoms could be confusion/rash.

Track:

An injection mark.

Tweaking:

A level of speed intoxication reached after one or two days of constant use, characterized by obsessive behavior.

Uppers:

Amphetamines.

Vaccine:

A preparation of killed, living attenuated, of living virulent organisms or part of microorganisms that can be administered to produce or increase immunity to a particular disease.

Virology:

The study of a virus - such as Human Immunodeficiency Virus (HIV).

Virus:

Submicroscopic organisms that grow and reproduce only inside living cells and thus cause disease.

Water:

Methamphetamine.

Watersports:

Urinating on the skin or into the mouth, vagina or rectum.

Well:

A state of well-being achieved by injecting heroin after being sick.

Western Blot:

A confirmatory test done if ELISA test is positive. It is analysis of blood serum or body fluid on an electric field. The proteins picked up in the ELISA test are measured. AIDS antibodies are recognized in this test. A way to tell the results of this test is to say "HIV test is positive."

Works:

Syringe/needle.

POLICIES

We recommend that shelters develop and enforce policies and procedures which cover the following issues:

- *Client, staff and volunteer confidentiality*
- *Guests with AIDS or HIV infection*
- *Staff and volunteers with AIDS or HIV infection*
- *Discrimination*
- *Possible accidental exposure to HIV on the job*
- *Information for pregnant personnel*
- *Action to be taken should policies be violated*

These policies should be written according to the beliefs of the individual organization and should be sensitive to the legal and ethical considerations to which they are accountable. This will help to deal with some of the fears that surround this virus by clarifying what steps can be and should be taken in the event that certain situations arise.

The following policies are examples of documents in effect at:

1. Bay Cove Human Services, Inc.
2. Pine Street Inn.
3. Lemuel Shattuck Hospital

BAY COVE HUMAN SERVICES, INC. AGENCY:

PROCEDURES REGARDING CLIENT CONFIDENTIALITY:

It is agency policy that steps be taken to protect the confidentiality of sensitive clinical information. Only those staff who have a need to know should have access to a client's medical and psychiatric records. Recently, the possibility that certain clients could become infected with a serious illness such as AIDS or hepatitis B has created an even greater need for strict rules regarding this client confidentiality than has been the case in the past.

Our agency needs to do everything possible to prevent other clients and persons outside of our program staff from obtaining information regarding the health status of our clients. This is vitally important if a client has AIDS since people who do not understand how this disease is transmitted often panic when they discover that someone they know has the virus. Other clients, family members of other clients and the general public might create very serious problems for our clients and our programs if they discovered a client was infected with AIDS.

For this reason, we ask that all staff study these regulations regarding the confidentiality of client information very carefully. Staff should know that violation of these procedures is sufficient grounds for immediate dismissal. Such a circumstance would be a tragedy for the client whose trust was violated, the program which might suffer considerable difficulties within the community and the staff person who would have to live with the knowledge that he or she might have caused a great deal of suffering for the client involved.

CONFIDENTIALITY PROCEDURES REGARDING STAFF WHO HAVE AIDS:

All staff are required to notify their supervisors if they will be absent from work due to illness. If an employee has AIDS or any other chronic, long term illness, he or she should inform the program manager that work absences may be frequent. The program manager may ask that the employee provide a doctor's written verification of the need for the employee to be absent from work for prolonged periods of time.

However, there is no requirement that an employee inform his or her supervisor of the specific diagnosis which requires absence from work. It is strictly the employee's personal decision as to what persons, if any, are informed of an AIDS diagnosis. Some employees may feel more comfortable sharing such information with their immediate supervisor or selected staff. Others may wish to keep this information confidential.

Ironically, there is a great deal of risk that a staff person with AIDS could catch some other disease from a client or employee...and virtually no risk that others would become infected with the AIDS virus, since the major cause of transmission of the disease is through sharing dirty needles or having sexual relations. Because a person with AIDS has so little immunity to all disease, it might be in the best interests of the staff person with AIDS to inform others so that they could warn the employee with AIDS if they had a cold.

In most cases, an employee infected with AIDS would discover that this diagnosis could no longer be kept confidential after obvious symptoms of the disease were apparent. At some point, it would be helpful for the employee to acknowledge in a discreet manner that AIDS was the reason for work absences. However, it will be the employee's own decision as to when, if ever, such acknowledgement is made.

Employees with AIDS will be treated no differently than any other employees who are ill. As long as the employee is able to perform the duties assigned to the job, the individual may remain employed. However, when an employee becomes too ill to be able to adequately meet the requirements of the position, this employee will be asked to resign. Hopefully, such a termination can be arranged in a manner which protects the confidentiality of the employee, to the extent that this is possible.

As a convenience, we have copied those sections of the agency's personnel manual which deal with employee sickness. These regulations apply to all types of illness including AIDS and hepatitis B.

PINE STREET INN AIDS POLICY:

REFERRALS

The Inn will accept referrals of guests with AIDS or ARC. Pine Street, however, is not an appropriate long term residence for persons with AIDS because of many other communicable diseases to which persons suffering from AIDS may be susceptible. Therefore, although we will accept referrals, the Inn should be considered only when all other alternatives have been attempted. The referring agency should continue to seek appropriate placements while the person is residing at the Inn.

ALTERNATIVE PLACEMENTS

A guest should not be refused accommodations simply because he or she has AIDS. A guest should be encouraged, however, to accept a more appropriate placement and other agencies encouraged to accept responsibility for finding a more appropriate placement when possible.

CONFIDENTIALITY

State and federal laws protect the confidentiality of people with AIDS, ARC or who test positive for HIV. Because precautions such as hand washing and wearing gloves are the expectation here, there is no legal justification for violating the confidentiality of our guests. If a guest shares this information with us, we can encourage him or her to share it with other staff as it seems appropriate, either for referral work or health care, etc. However, it is up to the guest to decide who should have this information.

STAFF INTERACTIONS WITH GUESTS WITH AIDS

It is the philosophy of Pine Street that our guests have the right to be treated with dignity and respect. While we recognize that there may be some staff persons who are not comfortable working closely with a guest who has AIDS, we believe we have a responsibility to see that this philosophy is conveyed to all guests by our attitude and that we work out among ourselves the division of responsibility for working with a particular guest.

PRECAUTIONS

Staff should assume that any guest is a potential carrier of the AIDS virus, and therefore, should use gloves when coming in contact with any body fluids (blood, urine, vomit, feces, etc.) from any guest. If accidental contact is made with body fluids, hands should be washed immediately. CPR should always be done with a protective face mask. However, day-to-day contact with guests, including those actually diagnosed with AIDS or ARC, requires no additional precautions. For more information, please contact the clinic.

EDUCATION

The Inn should initiate a program for informing guests about AIDS. The Inn should also continue to provide in-service training for staff on the topic of AIDS.

ADVOCACY

At the present time, the Inn will not be directly involved with advocacy in this area. However, we will continue to be in contact with other advocacy groups such as the AIDS Action Committee. We will also investigate the possibility of developing resources such as hospice for this segment of our population.

STAFF WITH AIDS

Should a staff person contract AIDS, he or she would be covered by all applicable sections of the Inn's Personnel Policies as would any other staff person. The decision whether or not to share information on one's condition would be up to the individual.

NOTE: For the purposes of this policy, ARC or positive HIV status may be substituted interchangeably wherever AIDS is mentioned.

EXCERPTS FROM LEMUEL SHATTUCK HOSPITAL INFECTION CONTROL POLICIES AND PROCEDURES A HOSPITAL APPROACH TO AIDS:

ACCIDENTAL EXPOSURES OF PERSONNEL TO HIV

Based on current information, a significant accidental exposure to AIDS is defined just as is a significant accidental exposure to hepatitis B, that is, accidental parenteral inoculation with blood or blood-contaminated instruments such as needles or other sharp instruments and mucous membrane or open skin lesion contact with blood or body fluids from AIDS patients. Extraordinary care should, of course, be taken to avoid such accidental exposures. Such accidental exposures do occasionally occur, however; and therefore, employees with such exposures should report promptly to the employee health office or to their supervisor.

If a caretaker has a parenteral (e.g., needlestick or cut) or mucous membrane (e.g., splash to the eye or mouth) exposure to blood or other body fluids, the source patient should be assessed clinically and epidemiologically to determine the likelihood of HIV infection. If the assessment suggests that infection may exist, the patient should be informed of the incident and requested to consent to serologic testing for evidence of HIV infection. If the source patient has AIDS or other evidence of HIV infection, declines testing or has a positive test, the health care worker should be evaluated clinically and serologically for evidence of HIV infection as soon as possible after the exposure and, if seronegative, re-tested after six weeks and on a periodic basis thereafter (e.g., 3, 6 and 12 months following exposure) to determine if transmission has occurred. During this follow up period, especially the first 6-12 weeks when most infected persons are expected to seroconvert, exposed caretakers should receive counseling about the risk of infection and follow U.S. Public Health Service (PHS) recommendations for preventing transmission of AIDS. If the source patient is seronegative and has no other evidence of HIV infection, no further follow up of the health care worker is necessary. If the source patient cannot be identified, decisions regarding appropriate follow up should be individualized based on type of exposure and the likelihood that the source patient was infected.

Also since these patients are often in high risk groups for hepatitis B, it would seem prudent to follow existing recommendations for hepatitis B prophylaxis.

PERSONNEL WITH AIDS OR SUSPECT AIDS

To date, there is no evidence that health care workers infected with HIV have transmitted infection to patients. A risk of transmission of HIV infection from health care workers to patients would exist in situations where there is both: 1) a high degree of trauma to the patient that would provide a portal of entry for the virus (e.g., during invasive procedures) and 2) access of blood or serous fluid from the infected health care worker to the open tissue of a patient as could occur if the health care worker sustains a needlestick or scalpel injury during an invasive procedure.

Health care workers known to be infected with HIV who do not perform invasive procedures need not be restricted from work unless they have evidence of other infection or illness for which any health care worker should be restricted.

Precautions to prevent transmission of HIV infection from health care workers (HCWs) to patients, regardless of whether they perform invasive procedure are:

1. *All HCWs should wear gloves for direct contact with mucous membranes or nonintact skin of patients.*
2. *HCWs who have exudative lesions or weeping dermatitis should refrain from all direct patient care and from handling patient care equipment until the condition resolves.*
3. *HCWs infected with HIV should be counselled about the potential risk associated with taking care of patients with transmissible infections and should continue to follow existing hospital policy for infection control to minimize their risk of exposure to other infectious agents.*

No information is available on the potential benefits or problems associated with the use of other active or passive immunizing agents or therapies in this situation.

PUBLIC RELATIONS

Public relations issues present both problems and opportunities. Some hospitals have found that the treatment of patients with AIDS has had adverse public relations consequences. On occasion, members of the press have placed disruptive and time consuming demands upon hospital staff. On other occasions, patients or members of the medical staff have placed inappropriate demands on the hospital such as by asking that AIDS patients not be treated in the institution. The hospital must not allow these disruptions to interfere with patient care.

In dealing with the press, careful and honest sharing of information will usually diminish adverse publicity and promote public education. This can be accomplished with the following in mind. First, patient confidentiality and dignity must be preserved. Second, a knowledgeable and authoritative representative of the hospital must designate a representative to the press, and other hospital staff members are required to coordinate all press communication through that representative.

PERSONNEL MANAGEMENT

Some health care personnel, including physicians, have been reluctant to provide hands-on care to AIDS patients. At this time, there is no evidence that the risks in doing so are any greater than the risks associated for caring for any other sick persons. The advisory committee recommends that otherwise healthy health care personnel should not be excused on their own request from providing care to patients with AIDS; there is no scientific or ethical reason to do so. If an employee simply refuses to perform his or her duties in relation to caring for AIDS patients, the issue becomes a legal and administrative problem to be resolved on an individual basis. Legal counsel is advised in this situation.

Health care personnel who believe they may be at increased risk because they are immunosuppressed or have other clinical conditions that may confer an increased risk of acquiring an infection should discuss their work responsibilities with the employee health office or with their own personal physician. If the physician determines that that person is indeed at an increased risk, or that there are certain work assignments that the employee should not accept in relation to the care of

AIDS patients, a written recommendation should be provided to the employing department for appropriate action in accordance with Lemuel Shattuck Hospital's personnel policies and procedures.

INFORMATION FOR PREGNANT PERSONNEL

There is no known increased risk to pregnant personnel from caring for AIDS patients. However, many patients with AIDS excrete large amounts of cytomegalovirus (CMV). Both the AIDS virus and CMV are a potential risk to the fetus. Hence, it is recommended that a practical approach to reducing the risk of infection with either the AIDS virus or CMV is to inform pregnant personnel of the potential for teratogenesis. Careful hand washing should of course be stressed after all patient contacts and avoidance of contact with areas or materials that are potentially infective. CMV virus can be shed in the urine, saliva, respiratory secretions, tears, feces, breast milk, semen and cervical secretions. To date, HIV has been isolated from blood, semen, saliva, tears, breast milk and urine and is likely to be isolated from some other body fluids, secretions and excretions but epidemiologic evidence has implicated only blood and semen transmission.

BIBLIOGRAPHY:

1. Lemuel Shattuck Hospital Infection Control Policies and Procedures
2. Pine Street Inn Employee Handbook

COMMUNITY RESOURCES

STATEWIDE TELEPHONE NUMBERS FOR INFORMATION AND HELP:

Spanish AIDS Hotline

..... Tel: 1-800-637-3776
..... Tel: (617) 262-7248

Somerville Portuguese American League (Portuguese/English)

..... Tel: 1-800-232-SPAL (National)

Coalition For The Homeless

Statewide coalition of client advocates and social service agencies serving the homeless. Central number for information on the Coalition

..... Tel: (617) 523-6400

Department of Elder Affairs (DEA)

Central number for information on DEA, Home Care Corporations and local area contacts

..... Tel: (617) 727-8931 Greater Boston 9:00-5:00 M-F
..... 1-800-882-2003 Toll Free Statewide 9:00-5:00 M-F

Department Of Mental Health (DMH)

Central number for information and District Office contacts:

..... Tel: (617) 727-5966 Carol Johnson 9:00-2:00

Department of Public Health (DPH)/AIDS Office

Central number for policy development, health services, advocacy, minority programs, public information, AIDS education and training:

..... Tel: (617) 727-0368

Department of Public Health (DPH)/Division of Alcoholism

Central number for DPH services:

..... Tel: (617) 727-1960
..... 24 hour Information and Referral: (617) 524-7884

Department Of Public Health (DPH)/Office Of Emergency Medical Services (OEMS)

Central number for information on OEMS services: Tel: (617) 451-3433

Department Of Public Welfare (DPW)

Central number for information on benefits and client advocacy: Client Services

Hotline: Tel: 1-800-841-2900 (Toll Free)/(617) 292-8900 (Boston)

Department Of Social Services (DSS)

Central number for general information and Region Office contacts:

..... Tel: (617) 727-0900

Executive Office For Communities And Development (EOCD)

Central number for information on Fuel Assistance and referral to CAP agencies:

..... Tel: (617) 727-3246/1-800-632-8175 (Toll Free Hotline)

Legal Services

Statewide back up center for information and referral to local Legal Services

Offices: Mass. Law Reform Institute Tel: (617) 742-9250

Massachusetts Centers For Disease Control (MCDC) AIDS Program

Central number for administration:

..... Tel: (617) 522-3700, ext. 484

New England Hemophilia Society

..... Tel: (617) 326-7645

New England Names Project

..... Tel: (617) 451-9003 or Karl (617) 723-6198

Office For Children (OFC)

Central number for information on OFC services and local area contacts:

..... Tel: (617) 727-8900

Veteran's Service Commissioner's Office

Information on benefits and local city and town Veterans' Agents, etc.:

..... Tel: (617) 727-3590, -4895, -4863 Call for appointment

United Way

Boston number for FEMA information and local office numbers:

..... Tel: (617) 482-1454 Information and Referral

..... Tel: (617) 482-8370 Ask for Government Relations for FEMA

Women, Infants And Children (WIC)

Nutritional Feeding Program

Central number for information and local service contacts:

..... Tel: (617) 727-6876/1-800-WIC-1007 Hotline

FOOD RESOURCES:

The following is a listing of statewide numbers to contact for information on emergency food advocacy and resources. Some of the benefit programs described in this manual (Food Stamps and WIC) do have emergency provisions for clients in emergency need. Additional emergency resources are available through the other emergency programs listed in the rest of this manual (such as FEMA, Fuel Assistance, AFDC & GR vouchers, etc.) and public/private resources.

Client Services Hotline (DPW): Information and advocacy on all benefits provided by the Department of Public Welfare including Food Stamps.

Boston number: (617) 292-8900 or 574-0400, Toll Free: 1-800-891-2900

Expanded Food and Nutrition Education Program (EFNEP): *The University of Massachusetts Cooperative Extension* program sponsors this program. EFNEP provides nutrition education for Food Stamp recipients. Nutrition aides are available to provide nutrition education to individuals and small groups on issues of food budgeting, menu planning and food preparation.

..... *Call toll free: 1-800-622-3637*

Food Stamp Hotline: Project Bread runs a statewide Hotline providing information and advocacy in the **Food Stamp** program application and eligibility. Their *toll free* number is

Toll Free Number: 1-800-645-8333

Nutrition Information Center: Information on basic nutrition for families, children and elders.

Toll Free Number: 1-800-322-7203

Project Bread Hunger Hotline: A research advocacy and fundraising group providing assistance to agencies developing food banks, soup kitchens, etc. This also is a direct service hotline for individual clients with specific food needs.

..... *Boston number: (617) 523-7010*

The Hunger Hotline also publishes:

"Guide to Free and Low Cost Meals in Greater Boston"

Available through:

**Project Bread Hunger Hotline
14 Beacon Street, #608
Boston, MA 02108**

Senior Meals: Through the State Department of Elder Affairs, congregate meals and meals on wheels (home delivery) are provided to seniors 60 years of age.

For information on the local congregate meal site or home delivery of meals contact

..... *Tel: 1-800-822-2003*

United Way Chapters: Many chapters have information on local food banks, soup kitchens and other free food sources.

The Central Boston number for local Chapter numbers is:

Tel: (617) 482-1454

Women, Infants and Children (WIC): Supplemental Food Program: Call for information on local WIC benefits and referrals to food banks, etc.

. Boston number: (617) 727-6876/Statewide number: 1-800-WIC-1007

HOUSING SEARCH AGENCIES:

Listed below are the non-profit agencies ("grantees") with whom EOCD has existing housing services contracts:

Brockton Area Helpline

837 North Main Street, Brockton, MA 02401 Tel: (508) 584-4298
ELAINE REISER, Executive Director/Carolyn Chase

Cambridge Office of Human Services

51 Inman Street, Cambridge, MA 02139 Tel: (617) 498-9076
Philip Mangano

City of Somerville/Office of Human Services

Somerville City Hall, Somerville, MA 02145 Tel: (617) 625-6000
JOYCE TAVON

Friendly House

36 Wall Street, Worcester, MA 01604 Tel: 508-755-4363
GORDON HARGROVE, Executive Director/Judy Brown

Franklin Community Action Corp.

39 Federal Street, Greenfield, MA Tel: (413) 774-2318
STANLEY GAWLE, Executive Director/Nancy Mitiguy

Housing Assistance Program

145 State Street, Springfield, MA 01103 Tel: (413) 785-1251
BILL BREITBART, Executive Director

Housing Information Center

205 Millbury Street, Worcester, MA Tel: (508) 757-2200
PAT LAMBERT, Executive Director, Ann Harreden

Lynn Economic Opportunity

360 Washington Street, Lynn, MA Tel: (617) 581-7220
JOHN ROBINSON, Executive Director/Barry Ingber

North Shore Community Action Program

98 Main Street, Peabody, MA 01960 Tel: (508) 531-06776
MARCH POTVIN, Executive Director

Rural Housing Improvement, Inc.

218 Central Street, Winchendon, MA 01475 .. Tel: (508) 297-1376/343-3416
L. ERNEST BRESH, Executive Director/Donna Thibault, Housing Service Director

South Middlesex Opportunity

36 Concord Street, Framingham, MA Tel: (508) 872-4853
JIM CUDDY, Executive Director/Emily Hunter

South Shore Housing Development Corporation

169 Summer Street, Kingston, MA 02364 Tel: (617) 585-3885

Tri City Community Action Program Housing Assistance Program

22 Mountain Avenue, Malden, MA 02148 Tel: (617) 322-4125

RON COURNOYER, Executive Director/Jill Laracombe, Advocacy Director

HOMELESS SHELTERS (All Provide Shelter):

METROPOLITAN BOSTON

Agnes B. Owens Family House

339 Dudley St. Roxbury MA 02119 Tel: (617) 424-0024

- **Services:** Food, Clothing, Referral, Counseling, Hotline, Family Life Worker, Housing Advocate
- **Clients:** Families (including men, but only with families); *no runaway, alcoholic or psychiatric services.*
- **Specialty:** eviction, fire, condo conversion - takes all others though
- **Length of Stay:** 3 months

Boston Crisis Shelter

32 City Square, Charlestown MA 02129 Tel: (617) 522-8886

- **Services:** Food, Clothing, Referral, Counseling
- **Clients:** Adolescents, *12-17 only*
- **Length of Stay:** 30 days

Boston Family Shelter

656 Mass. Ave., Boston MA 02118 Tel: 617/267-8081

- **Services:** Food, Clothing, Referral, Counseling, Relocation Assistance
- **Clients:** Family - must be referred by social service agency
- **Length of Stay:** 3 months

Boston Night Center

31 Bowker Street, Government Center, Boston, MA

- **Services** Food, Clothing, Referral, Counseling
- **Clients** Adult women and men
- **Length of Stay** Indefinite
- **Hours** 8:30pm - 6:30am

Bridge Over Troubled Waters, Inc.

147 Tremont St. at West St., Boston MA 02111 Tel: (617) 423-9575

- **Services:** Food, Referral, Counseling, Hotline
- **Clients:** Adolescents and runaways
- **Limitations on Services:** Overall services for those under 25;
- **Housing:** under 18 and *must be in counseling - no DSS placements*

Bristol Lodge Family Shelter

674 Moody St., Waltham MA 02154 Tel: (617) 647-9957

- **Services:** Food (3 meals), Referral, Counseling, Clothing (donations)
- **Clients:** Family, Adult men and women only with children; *no alcoholic or psychiatric services.*
- **Length of Stay:** 90 days

Bristol Lodge Family Shelter

674 Moody St., Waltham, MA Tel: (617) 647-9957

- **Services:** Food (three meals), referral, counseling, clothing (donations)
- **Clients:** Families, adult men and women with children; *no alcoholic or psychiatric.*
- **Length of Stay:** Indefinite

Bristol Lodge Individual Shelter

37 Lexington St., Waltham MA 02154 Tel: (617) 647-9957

- **Services:** Food
- **Clients:** Adult men and women, Alcoholic, Psychiatric
- **Length of Stay:** Indefinite

Cape Verdean Community House

SEE: Agnes B. Owens Family House, Roxbury, MA

Crossroads, Family Shelter Services:

56 Havre St., East Boston MA 02128 Tel: (617) 567-5926

- **Services:** Food, Clothing, Referral, Counseling
- **Clients:** Family (including men)
- **Length of Stay:** 4 months

Emergency Services Center/CASPER, Inc.

240 Albany St., Cambridge MA 02118 Tel: (617) 661-0600

- **Services:** Food, Clothing, Referral, Counseling
- **Clients:** Adult men and women, Alcoholic, psychiatric with alcohol problem
- **Length of Stay:** Based on need

Family House Shelter Program

252 Columbia Road, Dorchester MA 02121 Tel: (617) 427-4470 ext. 74

- **Services:** Food, Clothing, Referral, Counseling
- **Clients:** Families, including husbands; *no children over 13 for 90 day placements* - emergency 1 day placements when 90 day program full - *agency referrals only*
- **Length of Stay:** 90 days

Finex House

P. O. Box 1154, Jamaica Plain MA 02130 Tel: (617) 288-1054

- **Services:** Food and Clothing (donations), Referral, Counseling, Hotline
- **Clients:** Family (no men), disabled mothers with (disabled) children, Battered Women
- **Length of Stay:** 2 months

First Congregational Church

11 Garden St., Cambridge MA 02138 Tel: (617) 547-2724

- **Services:** Food (minimum)
- **Clients:** Adult men and women
- **Length of Stay:** Depends on circumstances

Fort Point Shelter

373 Broadway, South Boston, MA 02111 Tel: (617) 338-8414

- **Services:** Food, Clothing, Referral, Counseling, Medical/Health Care
- **Clients:** Adult men
- **Length of Stay:** No limit

Harbor Light

407 Shawmut Ave., Boston MA 02118 Tel: (617) 536-7469

- **Services:** Food, Clothing, Referral, Counseling, Hotline
- **Clients:** Adult men and women, Battered women; *No alcoholic*, Psychiatric case by case, (occasionally)
- **Limitation on Services:** Must be ambulatory
- **Length of Stay:** 3 days

Long Island Shelter/Long Island Hospital

Tobin Building, Boston Harbor MA 02169 Tel: (617) 328-8155

- **Services:** Food, Clothing, Referral, Counseling, Medical/Health care
- **Clients:** All adults, families on emergency basis, battered women, Alcoholic, Psychiatric
- **Length of Stay:** unlimited
- **Transportation to hospitals:** 3-7 p.m. from 784 Mass. Ave. (Boston City Hospital Laundry Building)

Meadowhouse, Inc.

205 Bacon St., Waltham MA 02154 Tel: (617) 899-7700

- **Services:** Food, Clothing, Referral, Counseling, Hotline, Advocacy, Case Management, Activity groups
- **Clients:** Youth 11 to 17 years old - Beaverbrook, Concord and Framingham areas
- **Length of Stay:** 30 days

New Chardon Street Shelter

SEE: Temporary Home for Women and Children, Boston, MA

Newton-Wellesley-Weston-Needham Multi Service Center

1301 Centre St., Newton Centre MA 02159 Tel: (617) 244-4802

- **Services:** Food, Counseling, Hotline, Family Therapy, 24 hour information and Referral, Discharge planning
- **Clients:** Adolescents 13-18 years old (local area only) including psychiatric which not actively psychotic, suicidal or violent; *Parent/guardian permission required.*
- **Length of Stay:** 30 days

Our Sister's Place

62 Berkeley Place, Boston MA 02116 Tel: (617) 542-7176

- **Services:** Helps women get on with life. Works with job training and apartment searches. *No shelter provided.*

Phillips Brooks House

SEE: University Lutheran Shelter, Association. Inc., Cambridge, MA

Pine Street Inn

444 Harrison Ave., Boston MA 02118 Tel: (617) 482-4944

- **Services:** Food, Clothing, Referral, Counseling, Medical Care
- **Clients:** Adult men and women
- **Length of Stay:** No limit

Project Hope

45 Magnolia St., Dorchester MA 02125 Tel: (617) 442-1880

- **Services:** Food, some Clothing, Referral, Counseling
- **Clients:** Families (20 beds) by interview process
- **Length of Stay:** 2 - 3 months

Quincy Crisis Center Mobile Unit

98 Phillips St., Wollaston MA 02170 Tel: (617) 471-7075

- **Services:** Food, Clothing, Referral, Counseling, Hotline, Housing search advocate
- **Clients:** Family (no men), Adult Women, temporarily if space available, some alcoholic (if in program), sometimes DMH referrals - screened for appropriateness in interview.
- **Length of Stay:** 1 day to 8 months

Quincy Interfaith Shelter Coalition

P.O. Box 2512, Quincy MA 02269 Tel: (617) 770-3314 (24 hour coverage)

- **Services:** Food, Clothing, Referral, Counseling, Case Management
- **Clients:** Family, Adult men and women, Battered women in emergency, Psychiatric if evaluated as not dangerous - must be 18 or over, no Boston clients.
- **Length of Stay:** no limit
- **Note:** *Admission by interview only.*

Renewal House

P. O. Box 919, Roxbury Crossing, MA 02120 Tel: (617) 566-6881

- **Services:** Food, Clothing (sometimes), Referral, Counseling, Hotline, Court Advocacy, Advocacy, Childcare
- **Clients:** Families in crisis, battered women, no males over 12
- **Length of Stay:** Max. 2 months

Rosie's Place

889 Harrison Ave., Boston MA 02118 Tel: (617) 442-9322

- **Services:** Food, Clothing, Referral, Permanent housing, Advocacy
- **Clients:** Family (in emergencies), Adult women, Battered women, Alcoholic, Psychiatric, no males over 12
- **Length of Stay:** Special program for one month for a few women. Two emergency shelter beds.

Saint Francis House/Day Shelter

39 Boylston Street, Boston, MA 02111 Tel: (617) 524-4211

- **Services** Food, Clothing, Referral, Counseling, Medical and Health Care.

Saint Paul's Shelter

24 Hartford St., Dorchester MA 02125 Tel: (617) 445-8461

- **Services:** Food, Clothing, Referral, (of Pine St. Inn), Counseling
- **Clients:** Women over 18 transported from Pine St. Inn Women's unit (they discourage walk-ins).
- **Length of Stay:** No limit

St. Peter/St. Paul Parish Shelter

55 West Broadway, South Boston MA 02127 Tel: (617) 268-8100

- **Services:** Some Food and Clothing
- **Clients:** Adult men referred by Traveler's Aid

Salvation Army

23 Vernon St., Roxbury MA 02119 Tel: (617) 427-6700

- **Services:** Food pantry and food vouchers while obtaining food stamps, Referral, Counseling, Advocacy
- **Clients:** Family (including legally married father)
- **Length of Stay:** 2 weeks or longer, depending on circumstances

Sancta Maria

11 Waltham St., Boston MA 02118 Tel: (617) 423-4366

- **Services:** Food, Clothing, Referral
- **Clients:** Adult Women
- **Length of Stay:** About 5 nights

Shattuck Shelter

Lemuel Shattuck Hospital, 170 Morton St., Jamaica Plain MA

..... Tel: (617) 522-8110 ext. 229

- **Services:** Food, Clothing, Referral, Counseling, Medical, Transitional program for working homeless
- **Clients:** Adult men and women, Battered Women, Runaways, Alcoholic, Psychiatric, Respite beds - *must be over 18, - no families with children*
- **Length of Stay:** No limit

Shelter, Inc.

P. O. Box 1056, Cambridge MA 02139 Tel: (617) 547-1885, -1774

- **Services:** Food and Clothing (for clients only), Case work
- **Clients:** Families (2 or 3 small), Adult men and women - no drugs or alcohol, non-violent - *no one under 18 without parent or guardian*
- **Length of Stay:** Varies (1-3 nights, families 2-3 months)
- **Note:** *Must have a referral*

Shelter Intake

784 Mass. Ave., Boston, MA 02118 (Boston City Hospital Laundry Building)

..... Tel: (617) 424-4741

- **Services** Food, Clothing, Referral, Counseling, Medical, Health Care.
- **Clients** All adult. One floor for women; one floor for men.
- **Length of Stay** Unlimited

Sojourner House

85 Regent St., Roxbury MA 02119 Tel: (617) 427-0622

- **Services:** Food (supplemental only) and Clothing (both when available), Referral, Counseling, Hotline, I and R, Housing counseling
- **Clients:** Only families (4) with no housing options
- **Length of Stay:** Negotiated

Somerville Coalition for the Homeless

P. O. 436, Somerville MA 02144 Tel: (617) 623-6111

- **Services:** Food, Clothing, Referral, Counseling, Medical care, Housing Advocacy
- **Clients:** Adult men and women
- **Length of Stay:** 6 weeks

The Somerville Corp. of the United Methodist Church Shelter

SEE: Somerville Coalition for the Homeless, Somerville, MA

Temporary Home for Women and Children

41 New Chardon St., Boston MA 02114 Tel: (617) 523-2337

- **Services:** Food, Clothing, Referral, Counseling, Whole social service program
- **Clients:** Only adult women and Battered women with children, *no boys over 11 1/2, no Alcoholic*
- **Length of Stay:** 45 days with extensions

University Lutheran Shelter

66 Winthrop St., Harvard Yard, Cambridge MA 02138 Tel: (617) 547-7297

- **Services:** Food, Clothing (donations)
- **Clients:** Adult men and women, no alcoholic or drugs

Women's Lunch Place/Church of the Covenant

67 Newbury Street at Berkeley, Boston, MA Tel: (617) 267-0200

- **Services:** Day shelter from 9:30 a.m. to 1:00 p.m. Serves hot lunch every day. Sometimes they have clothes.

WESTERN MASSACHUSETTS

Amherst Shelter for Adolescents

685 West St., Amherst MA 01002 Tel: (413) 256-6203

- **Services:** Food, Referral, Counseling, Adolescent Crisis Shelter serving DSS clients, offers counseling, assessment, referral.
- **Clients:** Primarily for adolescents (11-17) - *referral through DSS for Franklin & Hampshire counties only*
- **Length of Stay:** 30 days maximum

Armory St. Shelter

125 Armory St., Springfield MA 01109 Tel: (413) 739-2582

- **Services:** Referral, Counseling
- **Clients:** Family, Adult men and women, Battered women, Runaways, Alcoholic, Psychiatric
- **Length of Stay:** 21 days maximum

Berkshire Community Action Commission Family Shelter

292-296 West St., Pittsfield MA 01201

- **Services:** 3 meals, Referral, Counseling (social worker)
- **Clients:** Family, Pregnant women, Battered women with children, *no Alcoholic or Psychiatric*
- **Length of Stay:** Average 4-6 weeks

Cummings Memorial

148 Taylor St., Springfield MA 01105 Tel: (413) 732-0516

- **Services:** Food, Clothing, Referral
- **Clients:** Homeless and indigent men 18 and over, alcoholic, psychiatric
- **Length of Stay:** Depends on need
- **Note:** *There is a charge for services based on ability to pay*

Emergency Shelter of Greater Springfield

103 Prospect St., Springfield MA 01103 Tel: (413) 737-5518

- **Services:** Food, Clothing, Referral, Counseling, Hotline, Battered women referral
- **Clients:** Family, Adult men and women, Teenagers with children, Psychiatric (case by case, *generally no*)
- **Length of Stay:** 5 days single; 30 days family

Jessie's House (a. k. a. Hampshire County Emergency Shelter)

82 Bridge St., Northampton MA 01060 Tel: (413) 586-8212

- **Services:** Food, Clothing, Referral, Housing advocacy,
- **Clients:** Family, Adult men and women, no one under 18 without parent
- **Length of Stay:** 6-8 weeks

Loreto House

264 Elm St., Holyoke MA 01040 Tel: (413) 532-7859

- **Services:** Referral
- **Clients:** Family without husband, Adult women (*no men*), Battered women, Alcoholic, Psychiatric
- **Length of Stay:** depends on individual circumstances

Main Street Shelter

437 Main St., Holyoke MA 01040 Tel: (413) 536-2651

- **Services:** (for shelter residents) Food, Referral, Counseling
- **Clients:** Family, Adult men and women, no drugs or alcohol
- **Length of Stay:** Families: 30 days; Individuals: 5 days with extensions possible

Pittsfield Shelter

Pittsfield MA 01201

SEE: Berkshire Community Action Commission Family Shelter, Pittsfield, MA

Prospect Street Shelter

Springfield MA

SEE: Emergency Shelter of Greater Springfield, Springfield, MA

RAP (Runaway Adolescent Program)

Springfield, MA 01103

SEE: YWCA, Springfield, MA

The Shelter-Open Pantry

95 Jefferson Ave., Springfield MA 01107 Tel: (413) 736-2263

- **Services:** Food, Clothing, Referral Counseling, Hotline, Advocacy Health Services
- **Clients:** Women and children, Battered women, Runaways, very short term for alcoholic and psychiatric - *no males over 10*
- **Length of Stay:** 30 days

Springfield Rescue Mission

19 Bliss St., P. O. Box 2424, Springfield MA 01101 Tel: (413) 732-0808

- **Services:** Food, Clothing, Referral, Counseling, Hotline
- **Clients:** Family (limited), Adult men and Women, Battered women, Alcoholic
- **Note:** *Intake: 4:00 p.m.*

Urban Homeless

Springfield, MA 01109

SEE: Armory St. Shelter, Springfield, MA

Valley Opportunity Council

Chicopee, MA 01040

SEE: Main St. Shelter, Holyoke, MA

YWCA RAP (Runaway Adolescent Program)

137 Chestnut St., Springfield, MA 01103 Tel:(413) 732-3121

- **Services:** Food, Clothing (when donated), Referral, Counseling, Hotline, Services for Pregnant and Parenting Teens
- **Clients:** RAP - COED ages 12-17, 30 day limit, Battered Women; *No active drug or alcohol use, history of violent behavior, recent suicidal behavior.*

CENTRAL MASSACHUSETTS

Abby's House

23 Crown St., Worcester MA 01609 Tel: (617) 756-5486

- **Services:** Food, Referral, Hotline, Food Pantry, Day program
- **Clients:** Family, Women, Battered women, Runaways, Psychiatric
- **Length of Stay:** 10 days (flexible)

Blackstone Valley Task Force on the Homeless

Whitinsville MA 01588

SEE: Winterhaven Shelter, Milford, MA

Booth Home

24 Central St., Leominster MA 01453 Tel: (617) 534-9296

- **Services:** Food, Clothing, Referral, Counseling, Hotline
- **Clients:** Family, Adult women - fire/disaster victims, transients, evictions - no males (single)
- **Length of Stay:** approx. 6 weeks

Community Shelter Project of Greater Marlboro

Walker Building, Marlboro MA 01752 Tel: (617) 481-7847

- **Services:** Limited Food, Clothing (donations), Referral, Counseling
- **Clients:** Family, Adult men and women, Battered women, Alcoholics, Psychiatric
- **Length of Stay:** Unlimited, sometimes closed during summer

First United Methodist Church

Marlboro, MA, 01752

SEE: Marlboro Shelter, Marlboro, MA

Friendly House

36 Wall St., Worcester MA 01604 Tel: (617) 755-4362

- **Services:** Food, Clothing, Referral, Counseling, Hotline, Helping people find housing, Follow-up
- **Clients:** Family (including natural or married fathers), singles occasionally, Runaways case by case; *No Alcoholic or Psychiatric*
- **Length of Stay:** about 3 months

Gardner Community Action Committee, Inc.

175 Connors St., Gardner MA 01440-2669 Tel: (617) 632-8700

- **Services:** Food, Clothing, Referral, Advocacy (housing, welfare, food stamps, etc.)
- **Clients:** Family (first priority families with children), Adult men and women
- **Length of Stay:** 30 days - *more in special situations*

Luck Crisis

99 Day St., Fitchburg MA 01420 Tel: (617) 345-7353

- **Services:** Food, Clothing, Referral, Counseling, Hotline
- **Clients:** 3 apartments for abused adolescents (age 12-22), *by DMH/DSS referral only*
- **Length of Stay:** weeks to years

Marlboro Shelter

P. O. Box 5828, Marlboro MA 01752 Tel: (617) 485-7023

- **Services:** Food (limited), Clothing
- **Clients:** Adult men and women, Battered women, Runaways, Alcoholic, Psychiatric (*no psychiatric referrals*)
- **Length of Stay:** Not strictly defined

Our Father's House, Inc.

55 Lunenburg St., Fitchburg MA 01420 Tel: (617) 345-3050

- **Services:** Food, Clothing limited, Referral, (Housing and social services)
- **Clients:** Adult men and women, Alcoholic (*cannot take if intoxicated, on drugs or in psychiatric crisis*)
- **Length of Stay:** 5 days

Ozanam House/Catholic Charities

36 King St., Worcester MA 01610 Tel (617) 755-5349

- **Services:** Food, Clothing (by voucher), (Catholic Charities) Crisis Intervention, Counseling
- **Clients:** Adult men and women, *must have long term mental illness*
- **Limitations on services:** Greater Worcester area
- **Length of Stay:** 3 months

Pathways

59-61 Clinton St., Framingham MA 01701 Tel: (617) 872-4853

- **Services:** 3 meals, Clothing, Referral, Counseling (housing), Hotline
- **Clients:** Family, alcoholic, psychiatric
- **Length of Stay:** 3 months

Transitional Housing Program/Worcester YWCA

1 Salem St., Worcester MA 01608 Tel: (617) 791-3181

- **Services:** Clothing (sometimes), Referral, Counseling, Supportive Services
- **Clients:** Adult women, Alcoholic, Psychiatric *if under treatment, no children*
- **Length of Stay:** One year

Wayside Community Programs

108-110 Arlington St., Framingham MA 01701 Tel: (617) 872-6002/6008

- **Services:** Food, Referral, Counseling, Structured day program, family meetings
- **Clients:** Females 13-17, *not suicidal, drug addicted, or physically violent*
- **Length of Stay:** Up to 6 weeks

Winterhaven Shelter

St. Mary's Rectory, 27 Pearl St., Milford MA 01757 Tel: (617) 473-2000

- **Services:** Food, Referral, Counseling
- **Clients:** Family, Adult men and women, no drugs or alcohol
- **Length of Stay:** 4 weeks individual, family up to 3 months

Worcester Public Inebriate Program, Inc.

701 Main St., Worcester MA 01601 Tel: (617) 757-8331

- **Services:** Food, Clothing, Referral, Counseling
- **Clients:** Adult men and women, Runaways, Alcoholic, Psychiatric
- **Length of Stay:** No limit

Youville House/Catholic Charities

133 Granite St., Worcester MA 01604 Tel: (617) 753-3084

- **Services:** Food, Clothing, Referrals, Short-term counseling
- **Clients:** Families (Fathers included)
- **Length of Stay:** 90 days

NORTHEASTERN MASSACHUSETTS

Action, Inc. Emergency Shelter

24 Elm St., Gloucester MA 01930 Tel: (617) 283-7874

- **Services:** Food, Referral, Counseling, Advocacy (benefits, housing, income maintenance)
- **Clients:** Adult men and women from Gloucester, Rockport, Manchester and Essex area only - *no one under 18, no intoxication*
- **Length of Stay:** indefinite depending upon circumstances

Community Action Inc.

Haverhill, MA 01830

SEE: Emmaus House, Haverhill, MA

Community Teamwork, Inc.

Lowell, MA 01852

SEE: Pawtucket House/Merrimack House, Lowell, MA

Daybreak Shelter

75 North Parish Rd., Lawrence MA 01840 Tel: (617) 975-4547

- **Services:** Food, Clothing, Referral, Counseling, Transportation to Detox, Triage and Referral Network
- **Clients:** Adult men and women, Alcoholic, Psychiatric
- **Length of Stay:** no limit

Elder Emergency Shelter

420 Common St., Lawrence MA 01841 Tel: (617) 683-7747

- **Services:** Food, Referral, Counseling
- **Clients:** Adult men and women, no drugs or alcohol, possibly psychiatric
- **Length of Stay:** Up to one month

Emmaus House

105 Winter St., Haverhill MA 01830 Tel: (617) 373-7290

- **Services:** Food (sometimes), Clothes bank, Referral, Counseling, Family day care, Housing Search, Employment & Training (ET)
- **Clients:** Family, Adult men and women; *No drugs or alcohol*

House of Hope

812-814 Merrimack St., Lowell MA 01854 Tel: (617) 458-2870

- **Services:** Food (3 meals), Clothing vouchers, Referral, Counseling, Hotline, Job search
- **Clients:** Family, Adult men and women, Battered women, Runaways over 18, Psychiatric, No drugs or active alcohol
- **Length of Stay:** 3 nights, 10-14 possible for families

The Inn-Between

158 Main St., Peabody MA 01960 Tel: (617) 532-2372

- **Services:** Food, Clothing, Referral, Counseling
- **Clients:** Family, *Children must not be older than 15 years and 9 months.*
- **Limitations on services:** No untreated substance abuse problems in heads of households

Lawrence Street Shelter

Lawrence, MA 01840

SEE: Daybreak Shelter, Lawrence, MA

Lazarus House

48 Holly St., Lawrence MA 01842 Tel: (617) 689-8575

- **Services:** Food, Clothing, Referral, Counseling, Hotline, Advocacy
- **Clients:** Family (husbands too), Adult men and women, non-drinking and non-dangerous to self or others
- **Length of Stay:** 3 days

Lynn Emergency Shelter and Day Center

360 Washington St., Lynn MA 01901 Tel: (617) 581-7220 ext. 67

- **Services:** Food, Clothing, Referral, Counseling, Alcohol Drug Abuse Counseling, Detox arrangements, Advocacy I and R, Day Counseling Center
- **Clients:** Adult men and women (18 years and older), Alcoholic, Psychiatric, Substance abusers

North Shore Council

450 Maple St., Danvers MA 01937 Tel: (617) 777-2121

- **Services:** Food, Clothing, Counseling, on Alcoholism Hotline, Help finding jobs
- **Clients:** Adult men and women, Runaways, Alcoholic, Psychiatric
- **Length of Stay:** No limitation

North Shore Detox Homeless Program

450 Maple St., Danvers MA 01923 Tel: (617) 777-2121

- **Services:** Food, Clothing, Referral, Counseling, Housing placement, Employment Assistance
- **Clients:** Adult men and women, Alcoholic and drug (if sober or clean of drugs)
- **Length of Stay:** Up to 3 months if working

North Shore Shelter Committee, Inc.

315 Topsville Rd., Ipswich MA 01938 Tel: (617) 356-7414

- **Services:** Food, Clothing, Referral, Van pick up from Beverly, Salem and Peabody
- **Clients:** Adult men and women, others for emergency stays, alcoholics "dry shelter"
- **Length of Stay:** Indefinite

Pawtucket House/Merrimack House

167 Dutton St., Lowell MA 01852 Tel: (617) 459-0551

- **Services:** Food, Clothing, Referral, Counseling, Hotline
- **Clients:** Family (no singles)
- **Length of Stay:** 3 weeks with extensions
- **Note:** They have 2 shelters: 1 short term and one transitional (long term)

Project RAP

3 Broadway, Beverly MA 01915 Tel: (617) 922-0000

- **Services:** Referral, Counseling, Hotline
- **Clients:** Runaways (Ages 11-17)
- **Length of Stay:** 30 day maximum

Renewal House

Ipswich, MA

SEE: North Shore Shelter Committee, Ipswich, MA

Salem Mission

7 Crombie St., Salem MA 01970 Tel: (617) 745-1121

- **Services:** Food, Limited Clothing, Referral, Advocacy, Help making appointments, Nurses clinic, People from other areas welcome, Day services
- **Clients:** Adult men and women, lenient dry shelter, Psychiatric
- **Length of Stay:** On individual basis

Wellspring House, Inc.

302 Essex Ave., Gloucester MA 01930 Tel: (617) 281-3221

- **Services:** Food, Clothing, Referral, Counseling, a transitional house and a boarding house
- **Clients:** Family, Adult men and women
- **Length of Stay:** 6 weeks to 3 months

SOUTHEASTERN MASSACHUSETTS

David Jon Louison Foundation

195 West Elm St., Brockton MA 02401 Tel: (617) 587-6065

- **Services:** Food (occasionally), Clothing, Referral, Counseling
- **Clients:** Family (no single men), Runaways with children
- **Length of Stay:** As long as necessary

Family Resource Center

P. O. Box 2037, Attleboro MA 02703 Tel: (401) 226-5722

- **Services:** Food, Clothing, Referral, Counseling
- **Clients:** Family
- **Length of Stay:** About one month

Family Resources, Inc.

Middleboro, MA

CLOSED August, 1985

Family Shelter, The

87 Winter St., Hyannis MA 02601 Tel: (617) 771-5400

- **Services:** Food, Clothing, Referral, Hotline, Family life advocate, Housing services
- **Clients:** Family (no runaways)
- **Length of Stay:** 2 months

Housing Assistance Corp

Hyannis, MA 02601

SEE: The Family Shelter, Hyannis, MA

Hyannis Shelter

87 Winter St., Hyannis MA 02601 *Tel: (617) 771-0955/(617) 778-5255 (singles)*

- **Services:** Food, Clothing, Referral, Counseling
- **Clients:** Family, Adult men and women, Runaways (over 18),
Alcoholic, Psychiatric
- **Length of Stay:** 60 days

Mainspring House

54 N. Main St., Brockton MA 02401 *Tel: (617) 587-5441*

- **Services:** Food, Clothing, Referral, Counseling, Hotline, Outreach program
- **Clients:** Family, Adult men and women - minimum age for singles 18, free of substance abuse on intake
- **Length of Stay:** 30 day max. for singles, longer for families and unwed mothers

Marathon House

1303 Washington St., Walpole MA 02081 *Tel: (617) 668-3631*

- **Services:** Food, Clothing, Referral, Counseling (supportive), Transportation, educational groups (alcohol, drugs, living skills)
- **Clients:** Troubled teenagers 12-17 (Male and Female), *No substantial drug or alcohol, No suicidal, sexually acting out, psychiatric, criminally involved or fire setting*
- **Length of Stay:** 30-45 days

Market Ministries, Inc.

60 Eighth St., New Bedford MA 02740 *Tel: (617) 997-3202*

- **Services:** Food, Clothing, Referral, Transportation to and from Shelter when needed, Housing and job search assistance
- **Clients:** Family of three, Adult men (20) and (2) women or must be over 18 years old
- **Length of Stay:** Dependent on need

New Bedford Emergency Shelter

New Bedford, MA 02740

SEE: Market Ministries, Inc., New Bedford

New Start Shelter

Brockton, MA 02401

*SEE: Mainspring House, Brockton, MA***Reinhart Emergency Shelter**

1704 Acushnet Ave., New Bedford MA 02746 Tel: (617) 993-2557

- **Services:** 3 meals, Clothing, Referral, Counseling, Hotline, Housing search specialist, Social Service program
- **Clients:** Family (90% AFDC), Adult women, men if other shelter full, Runaway under DSS or other case responsibility, dry alcoholic or drug if in program
- **Length of Stay:** Depends on need

Shelter Care

452 South Main St., Fall River MA 02721 Tel: (617) 679-2109

- **Services:** 2 meals, Referral, Advocacy
- **Clients:** Families, Adult Men and Women, Alcohol and drug but *not under influence*, Psychiatric case by case, under 18 only with parent
- **Length of Stay:** Average of 2 weeks with extensions if serious about independence

Volunteers of America

1704 Acushnet Ave., New Bedford MA 02746 Tel: (617) 993-2557

- **Services:** Food, Clothing, Referral, Counseling (general and alcoholic/drug), Housing search
- **Clients:** Family (males included), single adult men and women when extra space, Battered women when BW shelter full, some handicapped - *must not currently be on drugs, alcohol, or be dangerous - no severe psychiatric*
- **Length of Stay:** 90 days if no special circumstances

AFDC - AID TO FAMILIES WITH DEPENDENT CHILDREN:

AFDC is a state and federally funded cash assistance program for needy children and their parents or relatives.

A. WHO'S ELIGIBLE?

- Pregnant women (starting at onset of pregnancy).
- Single parents with child(ren) under 18 years (or 19 if in school).
- Two parent families with child(ren) where one parent is incapacitated (reduced ability to work or care for children, lasting at least 30 days) or one parent has a work history (i.e. has collected Unemployment Compensation within last year or has worked off and on over the last 4 1/2 years) and is currently unemployed or working part time.
- Children living with another relative (sister, brother, aunt, uncle, grandparent, step-parent, etc.) as well as that relative if she or he too is in need.

B. BENEFIT AMOUNTS / INCOME LIMITS

AFDC recipients are sent a Medicaid card and bi-monthly checks. The maximum monthly benefits (as of July, 1987) for households with no other income is the amount in column B. Add an additional \$40.00 for a rent supplement if the household does not live in public or private subsidized housing. If the household has income, the total gross income (monthly) cannot exceed column C (185% of need standard). The household's available resources (cash, bank accounts, etc.) cannot exceed \$1,000.00.

A. Persons	B. Benefits		C. Max. Income Levels	
1	\$ 333.00	<i>Add \$40</i>	\$ 616.05	<i>Add \$74.00</i>
2	422.00	<i>to each if</i>	780.70	<i>to each if</i>
3	510.00	<i>eligible</i>	943.50	<i>eligible</i>
4	595.00	<i>for rent</i>	1100.75	<i>for rent</i>
5	682.00	<i>supple-</i>	1261.70	<i>supplement</i>
6	771.00	<i>ment</i>	1426.35	
	(90.00)		+ 166.50	

C. EMERGENCY AFDC BENEFITS

Any family or pregnant woman who "appears to be eligible based on the information available" during the first interview should be eligible for the following:

- **Emergency Assistance:** See the section on EA for a complete description.
- **Rent/Utility Vouchers:** in order to secure an apartment or utility (fuel) services. These vouchers are payable directly to the landlord/utility company and are deducted from the first check. Families who are eligible for Emergency Assistance, Fuel Assistance or other emergency benefits should look into these first to avoid the voucher deduction. (However, keep in mind that Emergency Assistance, once used, is not available again for another 12 months).
- **Food Vouchers:** to purchase food immediately. The food voucher is payable directly to a food store and is deducted from the first check. These vouchers should be offered only when the family is not eligible for emergency Food Stamps. (See Food Stamp section).
- **Medicaid:** Temporary Medicaid cards should be issued to AFDC families immediately when requested by the client. The doctor, hospital or clinic should accept the temporary card as proof of MA eligibility and should contact the Department of Public Welfare for further billing instructions on temporary cards.

NOTES

- Persons applying for AFDC cannot be denied benefits solely because they do not have an address so long as they intend to make their home in the state.
- Family Reunification Benefits (FRB) are available to AFDC families whose child(ren) are temporarily removed (voluntarily or involuntarily) by the Department of Social Services. The FRB program provides a continuation of the AFDC benefits for up to six month's following removal of the child and an additional three months prior to reunification. EA benefits are also available to this family.
- An AFDC applicant can provide alternative verifications (such as sworn statements from other persons) to verify such things as age of children, where "preferred" documents are not available. A worker must make an initial decision of AFDC eligibility and issue the emergency benefits within 24 hours.

D. OTHER RELATED BENEFITS TO CHECK

- **Food Stamps:** amount varies based on income and shelter/dependent care expenses. (See Food Stamp section.)
- **Emergency Assistance:** available to families with children under 21 years (regardless of school attendance) and pregnant women (see EA section).
- **Fuel Assistance:** available to families, couples, individuals depending on income. (See Fuel Assistance Section). Any family eligible for AFDC should also be financially eligible for fuel assistance.
- **Veterans Services:** if one of the parents in the AFDC household is a veteran or the spouse (i.e. widow) of a veteran, state-funded Veterans Services benefits may be available and are often greater than AFDC (See Veterans Services section).
- **Infant Benefits:** for the purchase of a crib (\$75.00) and clothing (\$50.00). The benefit is available for any infant 0 - 6 months through the AFDC program.
- **Funeral & Burial Expenses:** for deceased AFDC recipients, a maximum of \$1,100.00 is available through the AFDC program.
- **Lost/Stolen AFDC Checks:** rent, utility and food vouchers are available to AFDC recipients whose regular checks are lost or stolen. The total amount of the vouchers cannot exceed the lost check. The replacement check (or balance if vouchers are given) must be issued within 14 days if it was lost and 28 days if it was stolen.

E. HOW TO APPLY

- Applications for AFDC benefits are available at the local welfare office in the city or town where the person lives or a city or town nearby. Call the Toll Free number below in Section G for the local office address and phone number.
- To apply, a person must sign an application and bring proof of their eligibility. This proof includes birth certificates, social security numbers, rent receipts, wage stubs, bank statements, etc., if the person has these documents. "Alternative verifications", such as sworn statements from knowledgeable persons can also be accepted in most cases. Emergency benefits can be provided if the family or pregnant woman "appears to be eligible" based on the information they give when they apply.

F. APPEAL RIGHTS

- Any applicant or recipient has the right to appeal any Department action.
- If benefits are denied, request a fair hearing within 90 days of the notice.

- If ongoing benefits are reduced or terminated, request a fair hearing immediately within 10 to 14 days of the notice to continue the regular benefits. A fair hearing request can be still filed within 90 days, however, the benefits may not continue after 10 days.
- **Emergency Appeals:** the Division of Hearings has the power to schedule hearings within a few days if the person (or representative) requests immediate scheduling. The Appeals Referees have the discretion to issue expedited decisions. If an emergency situation exists, you should ask everyone involved to speed things up.

G. MORE INFORMATION AND HELP

If the above benefits are denied or if you need more information, call the Department of Public Welfare's Client Services Hotline:

Toll Free: 1-800-841-2900

Boston area: (617) 574-0400

If you need legal help, such as help with a fair hearing, call your local Legal Services office. See the Resource Section for telephone numbers.

SSI - SUPPLEMENTAL SECURITY INCOME:

SSI is a federally funded program to provide assistance to people with AIDS who are disabled and therefore unable to work. A positive HIV test does not necessarily qualify a guest for SSI. It also has benefits for those who are blind or aged. The benefits available under this program are more inclusive than those given for General Relief, therefore the eligibility requirements are stricter.

The primary requirement for SSI is that the applicant must be a disabled person whose incapacity (disability) is such that he or she is unable to perform any activity for pay. (Simply put, it means that you must be totally unable to work due to your physical condition). You must also have written documentation from a doctor explaining your disability. You need not have a permanent address to receive benefits, but the amount of benefits paid to the homeless is less than the amount paid to those with homes. The reason for this is that a homeless person does not have to pay for shelter.

The program has a category called presumptive eligibility. This means that if a case-worker decides you are in this category (in other words, you look like you need assistance), you won't have to wait for SSI benefits. You may receive benefits immediately and for up to three months while your application is reviewed and your disability is verified. You may also receive one month's advance check if you are in immediate financial need.

To apply for SSI, you must go to the Social Security Administration's District Office in your community. To find out where the office nearest you is located, call toll-free:

1-800-462-5015 between 9:00 a.m. and 3:00 p.m.

GR - GENERAL RELIEF:

General Relief is a state funded cash assistance program for families and individuals who are not receiving AFDC, SSI or other regular benefits.

A. WHO'S ELIGIBLE

Individuals who are age 16 years or older and are:

- unable to work (either full or part-time) for at least 30 days because of a mental and/or physical incapacity (as verified by a medical professional)
- Mass. Rehabilitation Commission participants
- Students, of any age, who are attending a high school or non-college training program
- ex-offenders recently released from prison (benefits last only 60 days from release date)
- 45 years of age or older with little recent employment
- 65 years or older and awaiting SSI benefits
- needed in the home to care for a disabled child or adult
- residing in a halfway house for drug or alcohol treatment
- Families who do not qualify for AFDC (usually because neither parent has a work history).
- Children who do not live with blood or adoptive relatives (or in some cases, who live with step- parents).

B. BENEFIT AMOUNTS/INCOME LIMITS

GR recipients are sent a Medicaid card (for limited coverage) and checks twice a month. The maximum current monthly benefits as of July, 1987 for households with no other income are based on the living arrangements listed below. An additional \$40.00 is added to these amounts for GR recipients who are not tenants in public or subsidized housing. The household's net income cannot exceed these benefit limits (unlike AFDC which has a higher eligibility limit). The household's resources (cash, bank accounts, etc.) cannot exceed \$250.00 for an individual and \$500.00 for a family or couple:

# of persons	"Group A"			"Group B"			"Group D"
	Living Alone or Boarding			Shared Living with others			Homeless or no shelter expenses
		<i>With rent Supplement (+ \$40)</i>			<i>With rent Supplement (+ \$40)</i>		
1	287.80			190.90			87.90
2	374.50			277.60			174.70
3	461.20			364.40			261.30
4	548.00			451.20			348.10
5	634.80			537.80			434.90
6	721.40			624.60			506.40
+	86.80			86.80			86.80

**AIDS RESOURCES, REFERRALS AND HOTLINES /
MASSACHUSETTS:**

AIDS Action Line / AAC Hotline Program

Tel: Boston (617) 536-7733/Statewide 1-800-235-2331 (Massachusetts only)

Both lines are TDD/Voice accessible (teletype device for the deaf):

Monday-Friday	9:00 AM - 9:00 PM
Saturday	10:00AM - 4:00 PM
Sunday	Noon - 4:00

AIDS Action Line Coordinator

..... *Tel: (617) 437-6200 x. 213 (Work)/(617) 787 1728 (Home)*

Boston City Hospital AIDS Hotline

..... *Tel: (617) 424-5916*

Staffed by nurses/medical information and support.

National Association of PWA / Boston

..... *(c/o AAC, 437-6200, leave message)*

SPANISH RESOURCES:

BOSTON

Latino AIDS Hotline

..... *Tel: (617) 262-7248*
(Monday - Friday Noon - 10:00 PM)

SPRINGFIELD

Bilingual AIDS information/referral

..... *Tel: 1-800-637-3776*
(Monday - Friday 9:00-5:00) *(413) 737-2632*

PORTUGUESE RESOURCES:

SPAL (Somerville Portuguese-American League)

..... *Tel: 1-800-232-SPAL*

MASSACHUSETTS POLICIES AND STATISTICS:

Massachusetts AIDS Resource Office

.....
(policies)

Tel: (617) 727-0368

HOTLINES:

AIDS Hotline For Spanish Speaking Persons

..... Tel: 1-800-344-7432
..... TTY 1-800-243-7889/Hearing Impaired

National Gay Task Force Crisis Line

..... Tel: 1-800-221-7044 / in NY/AK/HI (212) 807-6016
(AIDS Counseling)

Public Health Service

..... Tel: 1-800-342-AIDS
..... (in AK & HI only call collect) 202 245-6867
(AIDS information)

RESOURCES OF THE MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH:

**Massachusetts Department of Public Health
150 Tremont Street Boston, MA 02111**

AIDS Education and Training

(regional coordination, adolescent education, minority outreach, women's and pediatric issues) *Tel: (617) 727-0368*

AIDS Office

(policy development, health services, client advocacy / minority programs, public information) *Tel: (617) 727-0368*

REGIONAL AIDS EDUCATION

Central Region

AIDS Program, Northeastern Regional Health Office, Rutland Hospital, Rutland, MA 01543 *Tel: (508) 886-4711, ext. 323*

Northeast Region

AIDS Program, Northeastern Regional Health Office, Tewksbury, MA 01876 *Tel: (508) 727-7908*

Southeast Region

AIDS Program, Southeast Regional Health Office, Lakeville Hospital, Lakeville, MA 02347 *Tel: (508) 947-1231, ext. 572*

Western Region

AIDS Program, Western Regional Health Office, 23 Service Center Road, Northampton, MA 01060 *Tel: (413) 586-7525, ext. 63*

AIDS OFFICE / CLIENT ADVOCACY & EDUCATION PROGRAMS:

AIDS ACTION COMMITTEE (See pp. 43-49 for more in depth information)

131 Clarendon Street, Boston, MA 02111

LARRY KESSLER, Executive Director

..... Tel: (617) 437-6200

HAITIAN MULTI SERVICE CENTER

12 Bicknell, Dorchester, MA 02121

DAVID JOHNSON, Executive Director

..... Tel: (617) 436-2848

AIDS PROJECT WORCESTER

51 Jackson Street, Worcester, MA 01608

JOHN SAKOWICZ, Executive Director

..... Tel: (508) 755-3773

PROJECT CARE / New Bedford Area Center For Human Services

850 Pleasant Street, New Bedford, MA 02740

WARREN DAVIS, Executive Director

..... Tel: (508) 999-2321

BARNSTABLE COUNTY HEALTH & ENVIRONMENTAL DEPARTMENT

Superior Court House, Barnstable, MA 02630

..... Tel: (508) 362-2511 ext. 333

STETSON HALL, Executive Director

CAPE COD AIDS COUNCIL

P. O. Box 465, Hyannis, MA 02601 Tel: (508) 778-5111

PROVINCETOWN AIDS SUPPORT GROUP

c/o Provincetown Home Health Agency, 26 Alden Street

Provincetown, MA 02657

SANDRA LARDE, Program Coordinator Tel: (508) 487-2942

CAMBRIDGE HAITIAN AMERICAN ASSOCIATION

105 Windsor Street, Cambridge, MA 02139

ROLAND LAFOREST, Executive Director Tel: (617) 492-6622

DIGNILIFE, INC.

..... Tel: 1-800 228-AIDS
82 Temple Street, Springfield, MA 01105
ROBERT ABEL, Executive Director

GREATER LAWRENCE FAMILY HEALTH CENTER

..... Tel: (508) 975-3142
150 Park Street, Lawrence, MA 01841
EDIE MAAS, Executive Director

LIFE LINES AIDS PREVENTION PROJECT FOR THE HOMELESS

..... Tel: (617) 524-4709
c/o Shattuck Shelter
170 Morton Street, Jamaica Plain, MA 02130
SUZANNE GUNSTON, RN, Director

COMMUNITY BASED AIDS/HIV EDUCATION PROGRAMS:

ACTION FOR BOSTON COMMUNITY DEVELOPMENT (ABCD)

178 Tremont Street, Boston, MA 02111

..... Tel: (617) 357-6000 ext. 393

NORTHERN EDUCATIONAL SERVICES

622 State Street, Springfield, MA 01109

..... Tel: (413) 733-2238

NORMA BAKER

CHAMA - CAMBRIDGE HAITIAN AMERICAN ASSOCIATION

105 Windsor Street, Cambridge, MA 02139

..... Tel: (617) 492-6622

WOMEN'S PROJECT AIDS ACTION COMMITTEE

661 Boylston Street, Boston, MA 02116

..... Tel: (617) 437-6200

LARRY KESSLER, Executive Director

WOMEN FOR SOCIAL JUSTICE

108 Lincoln Street, 6th Floor, Boston, MA 02111

BETSY SMITH

HAITIAN MULTI-SERVICE CENTER

..... Tel: (617) 436-2848

12 Bicknell Street, Dorchester, MA 02121

EUSTACHE JEAN LOUIS

IBA/LHN INQUILINOS BORICUAS EN ACCION & THE LATINO HEALTH NETWORK

..... Tel: (617) 262-7248

405 Shawmut Avenue, Boston, MA 02118

LUIS GARCIA

INTERNATIONAL INSTITUTE

.....
454 Canal Street, Lawrence, MA 01840
GREG MILLER, Executive Director

Tel: (508) 687-0981

MULTI-CULTURAL AIDS COALITION

.....
c/o United South End Settlements, 566 Columbus Avenue, Boston, MA 02118
WAYNE WRIGHT, Executive Director

Tel: (617) 536-0390

NEW NORTH CITIZENS' COUNCIL

.....
2387 Main Street, Springfield, MA 01107
BARBARA RIVERA

Tel: (413) 737-2632

VNA / HOSPICES - DECEMBER, 1989:

Boston VNA

23 East Street, Cambridge 02141 Tel: (617) 577-7900, ext. 250
Bev Wancho

Hospice West

254 South Street, Waltham, MA 02154 Tel: (617) 894-1100
Ann Mitchell Dunbar

Provincetown Home Health

26 Alden Street, P. O. Box 1522, Provincetown, MA 02657 Tel: (508) 487-1864
Alice Foley

VNA of Cambridge, Hospice of Cambridge

186 Alewife Brook Parkway, # 206, Cambridge, MA 02138 Tel: (617) 547-2620
Dorothy Martin

VNA of Central Massachusetts, Inc.

120 Thomas Street, Worcester, MA 01608-1280 Tel: (508) 756-7176
Chris Bazoukas

VNA of Greater Lynn

16 City Hall Square, Lynn, MA 01901 Tel: (617) 598-2454
Debra Small

VNA Home Care Hospice, Inc.

1 Union Street, Andover, MA 01810 Tel: (508) 686-1010
Leslie Bresnahan

VNA of Pioneer Valley

P. O. Box 516, Springfield, MA 01151 Tel: (413) 781-5070
Chris Peacock

AIDS OFFICE CLIENT SERVICE PROGRAMS:

PEDIATRIC RESIDENCE

CHILDREN AIDS PROGRAM

.....
818 Harrison Avenue Boston, MA 02118
Deanna Forrest

Tel: (617) 424-5903

HIV/AIDS/OUTPATIENT SERVICES - INPATIENT SERVICES

SHATTUCK HOSPITAL

.....
170 Morton Street Jamaica Plain, MA 02130
Dr. Rochelle Schribe, Director

Tel: (617) 522-8110

PALLIATIVE CARE SERVICES

WESTERN MASSACHUSETTS STATE HOSPITAL / DPH

.....
91 E. Mountain Road Westfield, MA 01085
Supportive Community Residence

Tel: (413) 562-4131

CHESED HOUSE

.....
Located Westfield, MA. Operated by Jewish Family Services of Greater
Springfield.
Sandra Chalnack, MSW/MPH/MS

Tel: (413) 737-2601

INPATIENT RESIDENTIAL HOSPICE - UNDER DEVELOPMENT

HOSPICE WEST

18-20 Parker Hill Avenue, Mission Hill, Boston

Massachusetts Centers for Disease Control (MCDC) AIDS Program
305 South Street
Jamaica Plain, MA 02130

Administration *Tel: (617) 522-3700, ext. 485*

Behavioral Resources Program (BRP) / Boston

(information, support, and referral for HIV + asymptomatic persons)

. *Massachusetts DPH Tel: (617) 522-3700, ext. 472 or 473*

Counseling and Testing

Alternative Test Site (ATS) Program *Tel: (617) 522-3700, ext. 470 / 471*

HIV Counseling and Testing Training Program . *Tel: (617) 522-3700, ext. 494*

Sexually Transmitted Diseases (STD) Program . *Tel: (617) 522-3700, ext. 416*

Surveillance and Seroprevalence *Tel: (617) 522-3700, ext. 482*

HIV COUNSELING AND TESTING SERVICES:

ALTERNATIVE TEST SITE PROGRAM

The ATS program offers both scheduled and walk-in appointments for anonymous testing and counseling. Sites for scheduled appointments are listed first, followed by walk-in locations. To schedule appointments, except where otherwise noted, call (617) 522-3700, ext. 470 or 471 or call collect (617) 522-4090.

SCHEDULED APPOINTMENTS / ANONYMOUS

METROPOLITAN BOSTON

Massachusetts General Hospital	Boston
Somerville Hospital	Somerville
Lawrence Memorial Hospital	Medford
Fenway Community Health Center	Boston

*[for appointment, call (617) 267-0159] **

NORTHEAST REGION

Haverhill Board of Health	Haverhill
HealthQuarters	Beverly

WESTERN MASSACHUSETTS

University of Massachusetts Health Services	Amherst
Baystate Medical Services	Springfield
Red Cross	Pittsfield
Family Planning of Western Massachusetts	Holyoke

CAPE COD

Outer Cape Health Center	Provincetown
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WALK IN APPOINTMENTS / ANONYMOUS

METROPOLITAN BOSTON

Boston City Hospital Ambulatory Care Center	Boston
Ambulatory Care Center	(Wed. 2-4)
Public Health Clinic, 3rd Floor	(Fri. 2-4)
Dimock Community Health Center	Roxbury *
Linda Richards Building, X-Ray Department	(Thurs. 4-7)
Cambridge City Hospital	Cambridge *
Outpatient Department	(Tues. 5-7)

SOUTHEAST REGION

Stanley Street Treatment Center *Fall River **
ask for ATS Clinic (*Tues. 3-6, Wed. 4-8, Fri. 9-11*)
..... *Tel: (508) 679-5222, ext. 226*

CENTRAL MASSACHUSETTS

Framingham Union Hospital *Framingham*
Public Health Clinic (*Tues. 8:30-11:30*)
ask for LU-ANN KARB, RN

Worcester City Hospital *Worcester*
Public Health Center *Tel: (508) 799-8276*
ask for ANNE DECELLES, RN

WESTERN MASSACHUSETTS

Brightwood Riverview Health Center * (*Wed. 9-12*)
..... *Tel: (413) 784-4458*

** Denotes clinics that offer services in other languages as well as English.*

SEXUALLY TRANSMITTED DISEASE CLINICS

The following STD clinics offer both scheduled and walk-in appointments for confidential counseling and testing. Confidential testing requires the name of the patient to be given.

SCHEDULED APPOINTMENTS / NAME REQUIRED

METROPOLITAN BOSTON

Beth Israel Hospital Boston
..... Tel: (617) 735-4087
Call for appointment.

WESTERN MASSACHUSETTS

Berkshire Medical Center Pittsfield
..... (413) 443-1619

WALK-IN APPOINTMENTS / NAME REQUIRED

METROPOLITAN BOSTON

Beth Israel Hospital Boston *
..... Tel: (617) 735-4087
.. (Mon. 1-4; Tues. 9-11:30, 1-4, 5:30-8; Wed., Fri. 9-11:30, 1-4; Thurs.
..... 1-4, 5:30-8)
ask for CAROL LONDON, RN

Boston City Hospital Boston *
..... tel: (617) 424-4081
..... (Mon. Fri. 8:30-10:30; Mon., Thurs. 1-2)
ask for DIANE DUFFY, RN

Massachusetts General Hospital Boston
..... Tel: (617) 726-2748
..... (Mon. - Fri. 8:30-11)
ask for MELINDA SHOVAL

NORTHEAST REGION

St. Joseph's Hospital Lowell *
..... Tel: (508) 453-1761, ext. 1625
..... (Tues. 3:30-5:30; Thurs. 11:30-1)
ask for CONNIE NIEDZWIECKI, RN

Holy Family Hospital *Methuen **
 *Tel: (508) 687-0151, ext. 2432*
 *(Wed. 4-5:30)*
 ask for MYLENE CASSEL, RN

SOUTHEAST REGION

St. Luke's Hospital *New Bedford **
 *Tel: (508) 992-3855*
 *(Mon. 9-11; Thurs. 12-2)*
 ask for ROSA HERNANDEZ, RN

CENTRAL MASSACHUSETTS

Framingham Union Hospital *Framingham*
 *Tel: (508) 626-3540*
 *(Mon. 6-8; Fri. 1-1:30)*
 ask for LU-ANN KARB, RN

Worcester City Hospital *Worcester*
 *Tel: (508) 799-8276*
 *(Mon. - Fri. 8-10:30; Tues. 5:15-6:30)*
 ask for ANNE DECELLES, RN

WESTERN MASSACHUSETTS

Springfield Health Department *Springfield **
 *Tel: (413) 787-6129*
 *(Mon. 10-11:30; Tues. 10-11:30, 1-5; Thurs. 10-11:30)*
 ask for VICKIE WATSON, RN

** Denotes clinics that offer services in other languages as well as English.*

AIDS RESOURCES / BOSTON DEPARTMENT OF HEALTH & HOSPITALS:

PUBLIC HEALTH AIDS SERVICES

..... Tel: (617) 424-4276

Consultation on AIDS prevention and education for communities at risk in Boston.
EDUCATION COORDINATOR: BOB CARR.

BCH DEPT. OF AIDS ADDICTION SERVICES

..... Tel: (617) 424-5554

Prevention Outreach Workers. Available to do outreach with patients who have addiction problems.
MOLLY ASHLEY and MARSHALL CLARK.

DEPARTMENT OF NARCOTIC ADDICTION

..... Tel: (617) 424-5960

Addiction AIDS Education Coordinator. Provides education to all current and new patients in the drug clinic.
CHARLES KAPLAN.

- *There is no waiting list for patients referred from the immunodeficiency Clinic who have a positive HIV status and are symptomatic.*

IMMUNODEFICIENCY CLINIC/BOSTON CITY HOSPITAL

..... Tel: (617) 424-4290

Full service clinic managing patients in a primary care model that includes medicine, psychosocial, and pastoral counseling, and liasons with addictions services and AIDS Action Committee.
PROGRAM COORDINATOR: CONNIE HAGGARTY, R.N.

BCH EPIDEMIOLOGY NURSES

..... Tel: (617) 424-4801, 4551

Available to staff for questions/concerns regarding caring for the HIV infected patient.

PEDIATRIC INFECTIOUS DISEASE CLINIC

..... Tel: (617) 424-4841

Provides multi-disciplinary consultation, evaluation, education and treatment to high risk children on an out-patient basis. HIV testing and follow-up is available.

WOMEN'S CENTER HIGH RISK HIV TESTING

..... Tel: (617) 424-5084

Provides testing and counseling to women at high risk for HIV infection.
DORY CAMPBELL, R.N. Program Coordinator.

AIDS ADOLESCENT HEALTH EDUCATOR

..... Tel: (617) 424-4744

City of Boston Department of Health and Hospitals. Coordinates adolescent AIDS prevention efforts in school and community based programs. Provides education to adolescents, teachers and community members involved with adolescent AIDS prevention.
AIDS EDUCATION COORDINATOR: BOB CARR.

PSYCHIATRIC NURSING DEPT.

..... Tel: (617) 424-4943

Psych. nurses available throughout hospital for support and/or counseling to patients and consultation to staff.
LISA FAWNES and SHEILA LEVENSELER.

DEPT. NARCOTIC ADDICTION CONSULTATION SERVICE

..... Tel: (617) 424-4212

Provides evaluation and referral for In-patients with history of drug abuse.
JANET FORBES, R.N. Coordinator Beeper #106.

PUBLIC HEALTH NURSE T.B. DEPARTMENT

..... Tel: (617) 424-4875

TB treatment and prophylaxis. Education and referrals concerning AIDS and its connection with TB.
CAROLYN MURRAY.

STD CLINIC

..... Tel: (617) 424-5671

STD treatment, HIV counseling and testing if desired. Walk-in Monday am, Tuesday and Thursday pm, Friday am.

ALTERNATIVE TEST SITE AT BCH

..... Tel: (617) 522-4090

Must call for appointment. Free, anonymous HIV testing and counseling.
Wed. 1-5 and Fri. 1-5.

MEDICAL LIBRARY, ADMIN. BLDG. 2nd Floor

..... Tel: (617) 424-4198,9

NURSING LIBRARY, SO. BLOCK TOWER, 5th Floor

..... Tel: (617) 424-4926

The medical library is the repository of information regarding AIDS for DH&H. The library staff scans all incoming medical journals for current information which is placed in the AIDS files. The nursing library has a file on current information and articles for the nursing journals.

MARGI DEMPSEY, Director of Health Science Libraries.

SUPPORT AND SERVICES AVAILABLE TO YOU:

AIDS Action volunteers and staff are here to provide support and advocacy for you. All services are free, regardless of your ability to pay. Not everyone needs or wants all our services. However, the following listing will help acquaint you with what is available to you. You will have a staff contact person. To find out more about these services or any other things that might come up, please call us at 437-6200.

NETWORKING

People with AIDS and ARC get together or talk, share a meal, support each other. We can assist you in contacting other people in situations similar to yours.

SOCIAL SERVICES AND ADVOCACY

Through volunteers and staff, we can help assure you are getting the quality social service and health care to which you are entitled. We will work with hospital discharge departments and home care agencies and assist you in solving problems when you encounter them.

FINANCIAL COUNSELING/BUDGETING ASSISTANCE

Sometimes you may be confronted with difficult financial situations. Through help in budgeting and limited loans, we can provide you with extra resources in time of need.

SUPPORT SERVICES COMPANION PROGRAM

Trained volunteers are available on a one-to-one basis to provide you friendship, support, and a helping hand in everyday tasks from shopping and housework to lending an ear to talk to. You and your companion work it out together.

SUPPORT GROUPS

We offer a series of support groups for people with AIDS, ARC, their friends, family, and loved ones. These groups are available to you and your network to gain support and strength together.

COUNSELING SERVICES

We can refer you to a well trained mental health professional for individual, couples or family counseling. All counselors have a sliding fee scale and we will try to match you with the right counselor for you.

WHOLISTIC THERAPIES

We feel that a variety of approaches to health care can be helpful. Through referrals to individual massage, acupuncture, and chiropractic practitioners, as well as meditation, stress reduction, and attitudinal healing workshops. These practitioners can provide comfort, improved vitality, and symptomatic relief wherever possible.

LEGAL COUNSELING

A team of lawyers is available to help with legal issues including will consultations, power of attorney, as well as issues of discrimination.

TRANSPORTATION AND MOVING

Through a team of volunteers, we can assist with getting you to appointments from time to time. We can also help with moving if that is needed.

HOUSING

We have a commitment to helping you live in your own home and may be able to provide you with financial assistance to help pay your rent or mortgage. AAC has a small number of housing units which may be available to you if you are temporarily without a place to live due to AIDS or ARC. More information about this is available through your staff contact.

FOOD PROGRAM

Gift certificates to local markets are available on a limited basis to supplement your food budget if needed. Caring Kitchens is a "meals on wheels" program which can deliver food to you for a period of time.

PASTORAL COUNSELING

Referrals to "AIDS sensitive" pastoral and spiritual counselors are available through our Pastoral concerns committee.

RECREATIONAL AND CULTURAL ACTIVITIES

Recreational activities are organized as a way of spending time with other people and having fun. Your involvement in planning these events is welcomed. Other activities include outings, theatre tickets, as well as group projects "just for fun".

ANY QUESTIONS?? Please call your contact person at AAC

..... Tel: (617) 437-6200

HIV/ADDICTION SUPPORT GROUPS, compiled by Project Trust

Project Trust

Tuesdays 6-7:15 pm, call Ben/Brianne for information:

..... Tel: (617) 424-4495

Projects Trust

Monday 6-7:15 pm, Call Trust for information:

..... Tel: (617) 424-4495 or Warn, (617) 427-9276

Babysitting provided.

AIDS Action Committee

Thursday 6-7:30 pm. Our Lady of Victories Church. For information:

..... Tel: (617) 437-6200 ext. 271

V.A. Hospital

Monday 5-7 pm, call ILONKA THOMAS:

..... Tel: (617) 232-9500 ext. 277

Norcap Lodge

Friday 6-7:30, call ROBERT "BAZ" BAZINET for information:

..... Tel: (508) 543-6500

Merrimack Valley

Tewksbury Monday 7-9 pm:

..... Tel: (508) 851-0180

New Bedford, call LENNIE or LORRAINE:

..... Tel: (508) 997-9051

AA at AIDS Action Committee

AA for persons with addictive disease whose lives are affected by HIV disease.

Held at AAC Tuesday/Friday 7-9 pm:

..... Tel: (617) 437-6200 ext. 210

AIDS AND SUBSTANCE ABUSE

ISSUES FOR HEALTH CARE WORKERS

Barbara G. Faltz, RNC, BSN

Scott Madover, MFCC

The issue of AIDS and substance abuse raises critical clinical, ethical, and personal concerns for medical and mental health professionals. To develop effective strategies for coping with these concerns, health care providers need to consider first how substance abuse is linked to AIDS.

The most obvious connection is the direct transmission of the AIDS virus through the sharing of hypodermic needles, syringes, and paraphernalia while "shooting up" drugs. According to the Centers for Disease Control, intravenous (I.V.) drug use is the primary risk factor for 16 percent of people with AIDS. In addition, 11 percent of the gay and bisexual men with AIDS report a history of I.V. drug use. Thus a total of 27 percent of the people with AIDS have used I.V. drugs at one time or another.

Current statistics reveal that nearly 50 percent of the I.V. drug users with AIDS are black, 30 percent are Hispanic, and 20 percent are white. More than half of the women with AIDS in the United States are I.V. drug users; many of them are also sexual partners of I.V. drug users.

Another link between substance abuse and AIDS is the transmission of HIV by infected I.V. drug users to their sexual partners. Epidemiological data clearly reveal that HIV can be transmitted in this manner among heterosexuals as well as among homosexuals.

In addition, infected women who are I.V. drug users or who are sexual partners of users can transmit HIV during the neonatal period. There have been 217 pediatric cases of AIDS.

The connections between substance abuse and AIDS extend beyond the means of direct transmission. In recent cohort studies, a correlation was found between the use of volatile amyl and butyl nitrites ("poppers") and the development of Kaposi's sarcoma. Researchers have also established in laboratory studies the immunosuppressive effect of poppers. Earlier studies have confirmed the immunosuppressive role of alcohol, marijuana, cocaine, and amphetamines.

Being under the influence of alcohol or drugs can also affect a person's resolve to follow AIDS risk reduction guidelines. In a recent report prepared for the San Francisco AIDS Foundation, the Research and Decision Corporation cited the following findings after polling a sample of gay and bisexual San Francisco men:

there is a significant problem with drug use among the city's self-identifying gay and bisexual male population; and this problem may be perpetuating the AIDS epidemic. When asked if they were ever "high" or drunk while having sex, nearly one in five (18 percent) say they are at least so intoxicated that they would not want to drive a car.

While only three percent of the survey participants reported using I.V. drugs in the past six months,

these men also accounted for a significant percentage of high-risk sexual activities. In addition, 61 percent of the participants agreed that they were more likely to have unsafe sex when using alcohol or drugs.

Finally, alcohol and drug abuse can interfere with the medical treatment of AIDS. For example, the use of medication that is potentially hepato-toxic (toxic to the liver) is contraindicated in patients with a liver already damaged by alcohol or drug abuse.

Confronting the Patient with Substance Abuse Problems

Physicians and other health care workers often have difficulty in treating substance abuse disorders in patients who have AIDS or ARC. Health care providers often feel that the patient will die anyway, that substance abuse treatment will take away a "coping mechanism," and that treatment is too strenuous and confrontive. These concerns reflect a basic underlying question: "Why bother with substance abuse treatment?" Substance abusers themselves may provide the answer. Already troubled by the chaotic lifestyle that often accompanies substance abuse, many individuals find that the added crisis of an AIDS diagnosis prompts a careful look at the quality of their lives. Some may choose to get help to stop using drugs or alcohol. Others, of course, may continue current behavior, even at the risk of jeopardizing their eligibility for needed social services.

The choice to seek treatment or to remain actively addicted will be made by the client. Health care professionals often have trouble with this fact, yet it is basic to all effective treatment strategies.

Substance Abuse As a "Moral Issue"

Health care providers sometimes view substance abuse as a weakness or as a choice rather than as a disease. They may believe that treatment should consist of a lecture about "right" or "wrong" behavior, and they may advise clients to control their impulses. However, substance abuse is not a weakness; it is a chronic and progressive disease for which there is treatment and hope. Clinicians who view it otherwise may be reluctant to develop treatment strategies or to make effective referrals.

Behavioral Manifestations of Addiction

Many behavioral manifestations of addiction such as flattery, intrusiveness, intimidation, or inflammatory remarks can be frustrating for the health care provider. Clients often attempt to turn one staff member or agency against another. These behaviors can be attempts to avoid confrontation, to deflect attention, and to justify ongoing abuse.

Staff member should avoid expressing anger, blame, or disappointment toward clients who continue to use drugs or alcohol. At the same time, staff can encourage clients' constructive expressions of feelings. Staff can help prevent a sense of helplessness by holding clients responsible for their actions and by maintaining their own values, their commitment to quality care, and their professional standards.

Substance Abuse Assessment

An accurate and specific assessment of a client's substance abuse is essential to the clinician's understanding of the concerns and difficulties to be encountered. This assessment should include the amount, frequency of use, duration of use, and last use of all classifications of illicit drugs, mind-altering prescription medication, and alcohol. The following factors are helpful in determining the extent of a substance abuse problem:

- 1 emotional, social, relationship, employment, legal, or other difficulties that can be linked to the use of alcohol or drugs;
- 2 loss of control of frequency or amount of use;
- 3 preoccupation with drugs of choice or alcohol;
- 4 self-medication for anxiety or sadness with drugs or alcohol;
- 5 drinking or using drugs while alone;
- 6 rapid initial intake of drugs or alcohol;
- 7 protection of drug or alcohol supply — stocking or hiding supply;
- 8 tolerance to large quantities of alcohol or drugs;
- 9 withdrawal symptoms;
- 10 blackouts.

Once the health care provider has determined the extent and the effects of substance abuse, it will be helpful to assess the client's awareness of the problem and their willingness to follow treatment strategies.

People who actively pursue their addiction often feel little motivation for treatment, especially if they have not felt the painful consequences of their drinking or drug use. They may feel that the problem "is not bad enough yet" to seek treatment. Even if clients display limited motivation for treatment, it is important for clinicians to educate clients about specific AIDS risk reduction practices and to support changes in these areas.

It is natural for a person to engage in denial at the onset of a life-threatening illness. The denial usually continues until a person begins to absorb the impact of the diagnosis. Substance abusers, however, regularly employ denial as a chief defense against seeing the problems and effects of their addiction. Thus, health care providers can be most effective by challenging the denial of these clients and by helping them accept their AIDS diagnosis.

Priority Issues

Clinicians recognize so many other physical, emotional, financial, and legal concerns confronting their clients with AIDS that frequently they do not consider substance abuse as a priority to be addressed aggressively. However, not dealing with substance abuse issues can undermine other efforts to cope with the many problems that come with AIDS.

Current epidemiological data confirm the connections between substance abuse and AIDS. Projections for the future suggest that substance abuse will command even more attention from health care providers, educators, and health policy officials. While there are many problems associated with dual diagnoses of substance abuse and AIDS, health care providers can intervene effectively by first recognizing how their own values and anxieties impact upon treatment approaches. Next, they can accept substance abuse as a problem that can be ameliorated by treatment interventions. And, finally, they can be informed of community resources to help them make accurate assessments and to develop strategies.

In facing the dual problem of AIDS and substance abuse the community can utilize a variety of resources which are already in place. A method must be established for the coordination of medical, mental health, substance abuse, and community organizations related to this issue. In some communities a task force has been set up to recommend such coordination activities. Special

training to all persons involved relative to AIDS and substance abuse also has a high payoff for improving the quality of care to clients.

An added advantage of community networking related to this problem is the management of the difficult and manipulative client. Some clients have tried to misuse new services designed to meet this problem. Communication between agencies better enables these agencies to spot and control this inappropriate behavior.

This introduction to the issue of substance abuse and AIDS is based on an article first published in *FOCUS—A Review of AIDS Research*, August 1986.

INTRODUCTION

As the AIDS epidemic changes character in this country, particularly in the Western states, more patients will be admitted to hospital services whose HIV infection is related to substance abuse. This situation presents an opportunity for health care professionals to increase their knowledge about the dual diagnosis of HIV infection and substance abuse.

It is important to be aware that there are many different aspects and presentations that may be encountered from the substance abusing community. There is no one profile, no one behavior manifestation and no one outcome in treating people with substance abuse diagnosis.

The challenge of treating individuals who live in the shadow of AIDS must be faced simultaneously with the prospect of substance abuse. The implications of a shortened life span, medical uncertainty, public fear and a disease with a probable fatal outcome makes an additional treatment challenge for health care professionals.

Drug abuse in any form poses a direct threat to the body's immune system. Therefore, when a substance user encounters the AIDS virus it is with an already compromised immune system. Thus the course of the disease for the substance abuser is often rapid and more devastating.

Patients admitted to a hospital setting with a diagnosis of HIV infection are undergoing an enormous amount of psychological turmoil. At a time when their health is in deep peril, they're coping with concerns around death and dying, intimacy, guilt over past behavior and depression secondary to drug withdrawal. These patients will also be unaccustomed to quality medical care and unaware for numerous reasons of how to operate within the bounds of sound medical advice.

In this unit we will expand on the relationship between AIDS and substance use. Not merely IV use but also the connection between disinhabitation and increased risk taking behavior. Additionally, this unit contains a working definition of substance abuse, classifications of commonly abused substance and a glossary of drug terminology and euphemisms.

THE CONNECTION BETWEEN AIDS AND SUBSTANCE ABUSE *

The Link Between AIDS and Substance Abuse: Patient intervention strategies were based upon the premise that is essential to take a broad perspective of the issue of substance abuse and its effect on the development of an AIDS related diagnosis. In order to do this, we view the following as ways in which drugs, alcohol, and AIDS are linked.:

DIRECT TRANSMISSION

The first and most obvious link is the direct transmission of the HIV virus through the sharing of hypodermic needles, syringes, and paraphernalia used in "shooting up" drugs. According to the Centers for Disease Control, intravenous (IV) drug use is the primary risk factor for 17 percent of the people with AIDS. In addition, 8 percent of the homosexual and bisexual men with AIDS report a history of IV drug use, making a total of 28 percent of the people with AIDS IV drug users.

SEXUAL TRANSMISSION

The second link of substance abuse with AIDS is the transmission of the virus by infected IV drug users to their sexual partners.

NEONATAL TRANSMISSION

Thirdly, infected women who are IV drug users or who are sexual partners of IV drug users can transmit the virus during the neonatal period.

IMMUNOSUPPRESSION

A correlation between the use of volatile amyl and butyl nitrites (poppers) and the development of Kaposi's Sarcoma has been demonstrated. Although not directly linked to AIDS, alcohol, marijuana, cocaine, and amphetamines have been demonstrated to be immunosuppressant.

DISINHIBITION

Additionally, there is the factor of increased sexual risk and needle-using behavior while under the influence of alcohol or drugs. Persons who have made promises to themselves or others concerning behaviors that may increase risk of exposure to AIDS that have alcohol or drug abuse problems often, despite the best of intentions, are not able to keep these promises consistently.

INABILITY TO UTILIZE TREATMENT OR SERVICES

Alcohol and drug abuse interfere with the medical treatment of AIDS can sabotage social service and mental interventions. Financial problems, housing difficulties, and the exacerbation of emotional crisis situations are common consequences of substance abuse. They are particularly devastating accompanying a diagnosis of AIDS or ARC. Therefore, it is essential to rule out the presence of substance abuse disorders in people seeking HIV Antibody screening, those with AIDS Related Conditions and those diagnosed with AIDS when planning medical and mental health interventions.

*Faltz, B.G. and Madover, S., (1986) Substance abuse as a co-factor for AIDS. In Mc Kusick, L. ed., *What to do About AIDS: Physicians and health care professionals discuss the issues*. Los Angeles: University of California Press, pps 155-162.

WHAT IS SUBSTANCE ABUSE/ CHEMICAL DEPENDENCY?

Chemical dependency is the use of any psychoactive substance including alcohol to the degree that it interferes with physical, psychological, or social well being. In our society, use of certain substances to modify mood or behavior is regarded as acceptable and appropriate. To continue to use a substance despite adverse consequences, i.e. loss of job, involvement with the judicial system, relationship problems fulfills our definition of chemical dependency.

CLASSIFICATIONS OF COMMONLY ABUSED SUBSTANCES

Substances	Slang	Use	Withdrawal
CNS DEPRESSANTS			
alcohol	juice	euphoria	anxiety
Benzodiazepines (Valium & Librium)	downers	disinhibition	irritability
Barbiturates (Phenobarbital & Seconal)	reds	sedation	delusions
Qualudes	lemons, ludes		hallucinations paranoia
CNS STIMULANTS			
Cocaine	blow crystal	euphoria hyperactivity	depression apathy
Amphetamine	meth water crank	insomnia anorexia feeling of power	lethargy sleepiness
OPIATES			
Morphine	U.S.P.	euphoria	anxiety
Methadone	juice		irritability
Dilaudid	dillies	sedation	agitation
Fentanyl	China white		nausea & vomiting
Heroin	horse, smack, stuff	insomnia	
Percodan	tar		yawning
HALLUCINOGENS			
Marijuana	pot		depression
MDMA	ecstasy	hallucinatory	anxiety
LSD	acid		sleep pattern disturbance
PCP	angel dust		
		*PCP can also have violent dissociative effect.	

GLOSSARY

INTRAVENOUS DRUG USER TERMINOLOGY

ANGEL DUST — slang for PCP

BALLOON — a unit of measure similar to a bag

BAG — a unit of measure: ¼ gram, \$20-\$30

BASE — to smoke a specially prepared form of cocaine in a water pipe; a very fast and addictive high

BELUSHI — (after John Belushi) a speedball, alternative injections of cocaine and heroin

BOOT — to draw up blood into syringe and mix with substance usually cocaine

BOOST — to inject drugs; also to steal

CLEAN, CLEAN UP — to be drug free; to stop using

COOKER — a bottle cap or spoon used to heat and dissolve heroin in water

COTTON — heroin and other drugs are drawn into the syringe through a piece of cotton for filtration; well used cottons are boiled during scarce times

CRASHING — a state of physical discomfort and depression caused by stopping speed use, esp. after an extended period of use

CUT — a substance added to a drug that acts as an extender

DETOX — medical management of withdrawal from heroin; usually refers to 21 day methadone treatment

DILLIES — prescription synthetic morphine; very addictive

DIRTY — using heroin or speed, esp. after being clean

EIGHT BALL — ½ ounce of cocaine; street value \$250.00

FIX — to inject drugs, esp. heroin; an injection of drugs

FREEBASE — to smoke a form of cocaine in a water pipe; a smokable form of cocaine

GETTING OFF — to get high; the initial awareness of pleasure from injection

GUZZE — to inject drugs, usually heroin

HORN — to snort/sniff; usually refers to stimulants

KJ — "killer joint," marijuana cigarette with PCP

NEEDLE — usually refers to the entire syringe/needle combination

NOD, NODDING — a state of dreaminess induced by heroin

O.D. — overdose; ranges from unconsciousness to death

OUTFIT — syringe/needle

OVERAMP — overdose of speed, usually in the sense of too intense sensation

PCP — hallucinogen, originally a battlefield anesthesia; currently a horse tranquilizer

POINT — syringe/needle

REDI-ROCK — a small piece of specially prepared cocaine, often inserted in a cigarette for instant availability

RIG — syringe/needle

RUN — to inject drugs; ON A RUN — using IV drugs continuously

RUSH, RUSHING — the initial intense sensation felt when injecting drugs

SCRIPT — prescription

SHOOT UP — to inject drugs

SICK — the intensely painful period during withdrawal from opiates

SLAM — to inject drugs

SNORT — inhalation of a substance via nostrils; i.e. cocaine, crystal, Persian heroin

SPEEDBALL — mixing together cocaine (or speed) and heroin in a syringe

SPEED, SPEEDING — amphetamines, using amphetamines

SPOON — a utensil for dissolving and heating substances before injecting

STICK — to inject drugs

STRUNG OUT — heavily addicted

TRACK — an injection mark

TWEAKING — a level of speed intoxication reached after one or two days of constant use, characterized by obsessive behavior

WELL — a state of well-being achieved by injecting heroin after being sick

WORKS — syringe/needle

NAMES OF INJECTIBLE DRUGS

AMPHETAMINES — a class of CNS stimulants; incl. Benzadrine, Methadrine

BENZADRINE — 'Bennies'; a popular form of amphetamine

CHINA WHITE — previously, a high-grade heroin; now slang for Fentanyl

COCAINE — a short-acting stimulant in the form of a white crystalline powder; it can be injected, inhaled, or smoked

COKE — cocaine

CRACK — a form of cocaine prepared for smoking

CRANK — amphetamines

CRYSTAL — Amphetamines; particularly methamphetamine

DILAUDID — prescription synthetic morphine

DOWNERS — opiates or barbituates

FENTANYL — synthetic heroin; made in home labs, sometimes improperly, resulting in physical trauma

HEROIN — substance derived from morphine

METHADONE — legal synthetic heroin substitute; very addictive, intensely painful withdrawal cycle; dispensed through city programs

METHADRINE — brand name of methamphetamine

METHAMPHETAMINE — currently the most available form of amphetamine

MEXICAN BROWN — form of heroin originally of high quality; currently, heroin that has been 'cut' with brown sugar

MORPHINE — derived from opium; available by prescription

METH — slang for Methamphetamine as well as for Methadone

PELLETS — slang for ritalin

PERSIAN — a form of heroin; very addictive, difficult withdrawal

RAW — synthetic heroin, very strong

REDS — slang for barbituates, usually seconal

RITALIN — a stimulant in pill form; not a member of amphetamine family

ROCK — a solid piece of cocaine

SPEED — amphetamines

STUFF — heroin

TAR — a dark brown form of heroin from Mexico

UPPERS — amphetamines

WATER — methamphetamine

INTRODUCTION

The rapid spread of AIDS has presented enormous challenges for nurses who work with patients "at risk" for contracting the disease. Working with key issues, such as sexual behavior, health practices, intimacy, family relations, and death, are difficult to deal with when addressed individually. In the shadow of AIDS, all of them must be faced simultaneously along with the prospects of shortened lifetimes, medical uncertainty, and public fear and hostility.

These challenges are profoundly felt among nurses who work with substance abusers. Here, all of the issues normally faced by care givers of AIDS patients are present. But the situation is further complicated in this instance by at least three major aspects of the substance abuse problem:

1. *The nature of substance abuse itself:* This may result in the unwillingness to trust or believe your warnings concerning AIDS. In addition, they may perceive the threat posed by AIDS to be minimal.
2. *The position of substance abusers in society:* Because of their stigmatization within society, most substance abuse clients are not well served by the community groups which usually provide help to patients with HIV-concerns. Without many of the basic institutions to draw on, substance abusers are at a distinct disadvantage both in learning how to avoid AIDS and in coping with it when it occurs.
3. *Underlying health issues:* The substance abuser's underlying health is likely to be a strong contributor to the problem. Suspected "co-factors" to the development of AIDS that can often be consequences of substance abuse are poor nutrition, use of immune suppressing drugs, and repeated bouts of infection and illness.

The problems of AIDS and of substance abuse are both emotionally charged. The response of nurses and other health care workers will be, in part, a result of attitudes and beliefs about both issues. This section contains a self assessment tool, designed to enable you to define your view of substance abuse and to express your attitudes toward substance abusers with AIDS. In addition, there is a discussion of barriers to effective substance abuse intervention that have occurred for patients with AIDS.

SUBSTANCE ABUSE: SELF ASSESSMENT

This exercise is useful in identifying your feelings, concerns and opinions about patients with substance abuse problems and an HIV-related diagnosis. There are no "right" or "wrong" answers. Please be candid in your responses. Read each statement carefully and check () whether you:

1. Strongly disagree
2. Disagree
3. Neither agree nor disagree
4. Agree
5. Strongly agree

SELF ASSESSMENT – PART ONE

WHAT ARE MY FEELINGS AND BELIEFS ABOUT SUBSTANCE ABUSE?

Question:	Strongly Agree	Agree	Neither agree nor Disagree	Disagree	Strongly Disagree
1. Poverty and poor environment is a causes of substance abuse	<u>5</u>	<u>4</u>	<u>3</u>	<u>2</u>	<u>1</u>
2. The substance abuser is a victim of circumstance	<u>5</u>	<u>4</u>	<u>3</u>	<u>2</u>	<u>1</u>
3. If a substance abuser's environment is changed, use of drugs or alcohol will diminish	<u>5</u>	<u>4</u>	<u>3</u>	<u>2</u>	<u>1</u>
4. Substance abuse is a symptom of an underlying emotional disturbance.	<u>5</u>	<u>4</u>	<u>3</u>	<u>2</u>	<u>1</u>
5. The main goal of drug abuse treatment is to gain insight about the reasons a person uses drugs	<u>5</u>	<u>4</u>	<u>3</u>	<u>2</u>	<u>1</u>
6. Drug or alcohol abuse results from an inability to cope with life's problems.	<u>5</u>	<u>4</u>	<u>3</u>	<u>2</u>	<u>1</u>
7. What substance abusers need is advice to quit or cut down on their use.	<u>5</u>	<u>4</u>	<u>3</u>	<u>2</u>	<u>1</u>
8. Substance abuse is a moral issue.	<u>5</u>	<u>4</u>	<u>3</u>	<u>2</u>	<u>1</u>
9. Jail sentences for possession of narcotics are more effective in curbing drug abuse than are drug diversion treatment programs.	<u>5</u>	<u>4</u>	<u>3</u>	<u>2</u>	<u>1</u>
10. A substance abuser has a chronic, progressive illness.	<u>5</u>	<u>4</u>	<u>3</u>	<u>2</u>	<u>1</u>
11. Alcoholism may have a biological basis.	<u>5</u>	<u>4</u>	<u>3</u>	<u>2</u>	<u>1</u>
12. Addiction can't be cured.	<u>5</u>	<u>4</u>	<u>3</u>	<u>2</u>	<u>1</u>

Compare your score to the table below to categorize your view of substance abuse. The current belief is that discussed elsewhere in this manual is that of the "disease concept." (See the following table for a summary of four views of substance abuse.)

Questions:	Score	Model of Substance Abuse
1-3	Total score over 9	Problem with society/environment
4-6	Total score over 9	Result of mental disorder
7-9	Total score over 9	Moral problem
10-11	Total score over 9	Chronic, progressive, disease

DIFFERENCE OF OPINION AMONG FOUR MODELS FOR TREATMENT OF SUBSTANCE ABUSE

MODEL:	PSYCHIATRIC: Symptom of emotional problem	SOCIOCULTURAL: Victim (society makes him that way)	MORALISTIC: Hustler — morally weak	MEDICAL: Person with disease
CONCEPTION OF ALCOHOLIC:	Emotionally disturbed	Victim of circumstance	Morally deficient	Has chronic, progressive, illness
CONCEPTION OF TREATMENT PROCESS	Emotional conflicts resolved with insightful psychotherapy	Addictive circum- stances removed with emotional & social supports	"Addict behavior" confronted, admitted to, & replaced by responsible behavior	Educ. about & exploration of symptoms and progression of disease. Confron- tation of denial of dx. Planning for relapse prevention
TREATMENT PROVIDERS	Mental Health Professional	Social Service Professionals	Member of Clergy	Substance Abuse Program AA, NA
CONCEPTION OF TREATMENT OUTCOME	Emotional rehabilitation	"Normal" self emerges	Moral recovery	Recovery process begins

Based upon Davis, W.N. "The Treatment of Drug Addiction." *British Journal of Addiction* 1970 (11) 227-235.

SELF ASSESSMENT – PART TWO

ATTITUDES AND BELIEFS REGARDING THE SUBSTANCE ABUSER

Question:	Strongly Agree	Agree	Neither agree nor Disagree	Disagree	Strongly Disagree
1. Once a person is infected with HTV there is no point in initiating drug abuse treatment.	5	4	3	2	1
2. Substance abuse is not prevalent in women.	5	4	3	2	1
3. You can only help a person with a drug problem if they initiate a request for treatment.	5	4	3	2	1
4. It is difficult to be sympathetic to IV drug users who get AIDS.	5	4	3	2	1
5. Drug addicts are less concerned about their health than others.	5	4	3	2	1
6. Drug abusers, as patients, usually request pain medications whether they need it or not.	5	4	3	2	1
7. Drug abusers who are chronic complainers need not be taken seriously when they complain of discomfort.	5	4	3	2	1
8. Transfusion recipients and children are the innocent victims of AIDS.	5	4	3	2	1
9. If drugs were made legal, violent crime would decrease.	5	4	3	2	1
10. It is difficult to be sympathetic to homosexuals who get AIDS.	5	4	3	2	1
11. No more than 10% of hospital admissions result from drug or alcohol abuse.	5	4	3	2	1
12. Dealing with alcoholism or drug abuse behavior is beyond the scope of nursing practice.	5	4	3	2	1
13. A nurse should have the right to refuse care to an AIDS patient.	5	4	3	2	1
14. The difference between use and abuse of drugs is in the amount used.	5	4	3	2	1
15. A nurse should have the right to refuse care to a drug abuse patient.	5	4	3	2	1
16. Alcoholism is not as serious a problem as drug abuse.	5	4	3	2	1

Question:	Strongly Agree	Agree	Neither agree nor Disagree	Disagree	Strongly Disagree
17. Cocaine is not as dangerous as the media makes it seem.	<u>5</u>	<u>4</u>	<u>3</u>	<u>2</u>	<u>1</u>
18. A person who commits a crime "under the influence" of alcohol or drugs should not be held responsible for it.	<u>5</u>	<u>4</u>	<u>3</u>	<u>2</u>	<u>1</u>
19. Drug or alcohol abuse in a parent should be hidden from the children to protect them.	<u>5</u>	<u>4</u>	<u>3</u>	<u>2</u>	<u>1</u>
20. The relationship between physical or sexual abuse and the use of drugs or alcohol is negligible.	<u>5</u>	<u>4</u>	<u>3</u>	<u>2</u>	<u>1</u>

SCORING

Add you total score and compare it to the table below.

<i>Point score</i>	<i>Ease in working with substance abusers</i>
1 - 20	Generally at ease in working with substance abusers. Interactions tend to be therapeutic.
21 - 40	Relatively at ease in working with substance abusers with HIV. May benefit from reading list to increase knowledge.
41 - 80	Have some discomfort in working with substance abusers with HIV. May benefit from reading list to increase knowledge and comfort level.
81 - 100	May have considerable fear or discomfort in working with substance abusers with HIV. Do not give up! Your honesty and candor are gifts that can help you learn more about both AIDS and about substance abuse. Increased knowledge can lead to more successful interventions with this population.

BARRIERS TO SUBSTANCE ABUSE TREATMENT

Substance abuse in a person with HIV infection or a diagnosis of AIDS or ARC can have profound consequences. The patient and loved ones are often traumatized by the diagnosis and loved ones may be reluctant to confront the patient's substance abuse. Physicians and other health workers also may overlook substance abuse in persons diagnosed as having AIDS or ARC. They may perceive the disease to be their most immediate concern and the substance abuse an ancillary issue for which a referral may be offered.

The combined problem of AIDS and substance abuse raises critical clinical, ethical, and personal dilemmas for patients, loved ones, and health care providers. The perplexities of this situation often lead to barriers to effective substance abuse treatment for individuals at risk for HIV infection, and/or diagnosed with AIDS or ARC.

THE "WHY BOTHER?" MENTALITY:

Because of the overwhelming nature of an HIV related diagnosis, treatment providers as well as patients often feel a sense of hopelessness that precludes the possibility of major B. Faltz and S. Madover positive life changes. Rationales for ignoring drug or alcohol abuse and the possibility of successful treatment for it include: that the patient will die anyway, that substance abuse treatment will take away a "coping mechanism," and that substance abuse treatment is stressful. These rationales imply the question "Why bother treating substance abuse in patients with AIDS?"

This reasoning implies either that the quality of life is a moot issue once an individual has an HIV related diagnosis, or that somehow substance abuse will make it easier for the patient to endure his or her illness. What treatment providers may not realize is that the crisis brought about by this diagnosis may provide an opportunity to make a powerful intervention in an individual's substance abuse and that the patient's quality of life may improve as a result.

For an individual troubled by the chaotic lifestyle that often accompanies drug or alcohol abuse, the crisis evoked by an AIDS diagnosis may generate a willingness to ask, "What will I do with the rest of my life?" The patient may choose either to get treatment for the abuse or to continue it. Many do choose to "die high." However, health care providers can play a positive role in facilitating conscious choices and in making avenues of treatment available to the patient. Too often, however, those providing care for patients with HIV related risk or infection are not working in coordination with substance abuse providers. As a result, they sometimes overlook the importance of both kinds of treatment for the patient's well-being.

HEALTH WORKERS PERCEPTIONS AND FEARS:

Another barrier to substance abuse treatment among HIV infected patients is the personal perceptions and fears of health care providers triggered by contact with these patients. The following have been identified as issues in treatment providers of AIDS patients: fear of the unknown, fear of contagion, fear of death and dying, fear of homosexuality, denial of helplessness, over-identification with the patient, anger, and the need for professional omnipotence.* These difficulties

TOUGH LOVE

One of the problems we encounter in specialized fields such as treating alcoholics is that we develop a jargon all our own and sometimes we fail to communicate the meaning of certain phrases that we use to others. One such term is "tough love." We use it a great deal in our treatment, and in AA, yet I believe that each one of us carried around a different definition of what "tough love" means to me.

The term "tough," I define it as follows: I will not do anything for you that you can do for yourself. "Love" is defined as: 1. Non-judgmental, 2. acceptance, 3. empathy, 4. understanding. When we combine these two terms we have, I believe, the basis of the treatment philosophy of a Half-Way House.

By being tough, yet loving, we avoid carrying the person, we avoid making the person feel obligated to us. We avoid manipulating the person to make them feel that we are doing everything for them and if they don't respond with what we want we will be mad, hurt, etc., etc. Being tough helps the person build their self-esteem and self-image by helping them build the ability to respond. Of course, we do not necessarily say it in so many words, but more often than not, we say that our clients can do something and we know full well that we have made them reach a little further than their grasp. By extending the client's reach beyond his grasp we help him grow, and reach his full potential.

Why is she or he in our half-way house? If the motives of the client are to obtain "three hots in a cot" and then take off at the earliest possible moment and resume their drinking, then the "Tough Love" will bring this out. If their motive is to obtain sobriety to work on it, to return to society as a responsible contributing member, being tough helps them build towards this goal.

"Tough Love" in the final analysis is meant to build a strong, independent self-sustaining individual, one who can cope in society without alcohol. However, "Tough Love" is not only for the client, it is also for the alcoholism counselor. "Tough Love" will ferret out those counselors who have a deep-seated desire, be they male or female, to mother, nurse, coddle, and otherwise burp their clients as if they were newborn infants. The results of the practice of "Tough Love" is not one where vindictiveness or cruelty prevail, nor where marshmallow or syrupy sweet gushiness abounds. Where "Tough Love" is practiced beautiful people grow, and alcoholics recover.

(Dan Spiro, Director, Bridgeway Halfway House, Rockford, Illinois — borrowed from Counselors on Alcoholism Newsletter)

